

What is covered in an emergency room visit?

Includes all services done in emergency room. Emergency room services will not be covered if admitted to hospital (stay over 24 hours). Emergency Room services are covered at the same rate for in and out of network providers.

Are services rendered in an urgent care facility covered?

Urgent Care is covered the same as the physician visit benefit. The exam and lab/x-ray benefit will be separate copay as listed in the schedule of benefits. All surgeries including stitches, setting of broken bones, etc. are not covered.

Are maternity services covered? Pre-Post Natal Care? Ultrasound? Delivery?

Services for pregnancy and pre-natal care are covered. The pregnancy services listed under preventive care will be covered at the preventive benefit. Preventive care for maternity would include (but not limited to) pre-natal care, breastfeeding support and supplies, folic acid supplements and gestational diabetes screening. Ultrasounds and non-routine pregnancy services will be covered the same as any other illness. Delivery and inpatient charges including nursery are not covered.

Are mental health and substance abuse services covered?

Mental health and substance abuse services are not covered under the plan unless listed in the preventive care schedule (example, screenings for depression over age 12 are covered but treatment for depression is not covered).

Are contraceptives covered?

Approved contraceptives would be covered in-network at 100% at the pharmacy, as they are considered part of the preventive/wellness benefit.

Is surgery covered?

Surgery, whether inpatient, outpatient or in the office, is not covered under the plan unless it is listed under the preventive/wellness benefit, such as a routine colonoscopy. This includes stitches, removal of moles, setting of bones, etc.

How are MRI, CAT/CT, PET scans covered?

MRI, CAT/CT and PET scans are covered with a \$400 copay and then at 100% per service. If rendered in an emergency room (ER) these would be covered under the ER copay and benefit. The \$400 copay will cover the physician and facility charge when rendered on an outpatient basis in a hospital, independent clinic or office setting. The inpatient facility charge of an MRI, CT, PET scans is not covered.

What is covered when I go to the doctor's office?

If it is an illness or injury visit, the exam would be covered under the physician benefit after a copay. There is a difference between Primary Care Physician or Specialist exam copays (see summary below or plan document). Lab and x-ray's done in the office, again for illness or injury, are a separate benefit and copay for each service line billed. Wellness exams are covered under the preventive

care/wellness benefit at 100% in network. Some lab and x-rays related to wellness may also be considered under this benefit. Surgery will not be covered.

Are durable medical equipment and prosthetics covered?

All medical supplies, durable medical equipment and prosthetics are not covered under the plan.

Are biotech/specialty medication covered?

All biotech and specialty medications through either the pharmacy or other setting/place are not covered under the plan. This includes specialty medications given through infusion.

Are ambulance services covered?

Ambulance services are not covered. This includes ground, air, sea, etc.

Is chiropractic care covered?

Chiropractic care is not covered. This includes exam and all services rendered by a chiropractic provider.

Is infusion therapy, chemotherapy, or radiation covered?

Infusion, chemotherapy and radiation are not covered.

What preventive/routine services are covered?

Preventive care/wellness services will be covered in-network at 100% based on the 63 CMS mandated preventive care listing. Please see the plan document for the complete listing.

Are domestic partners covered?

Yes as long as the requirements stated in the plan document are met.

What is the benefit period?

The benefit period runs from January to December.

Are injections or shots covered?

Injections, whether inpatient, outpatient or in the office, are not covered under the plan unless it is listed under the preventive/wellness benefit, such as a routine immunization. This includes antibiotics, steroids, allergy injections, etc.

How is a healthcare provider defined?

Healthcare providers are defined as physicians or licensed healthcare professionals that are acting within the scope of their license. This includes physician assistants, nurse practitioners, licensed clinical social workers, etc.

How is the allowed amount for out of network claims determined?

The 90th percentile of usual and customary will be used.

Are inpatient services covered?

Inpatient facility services are not covered. Physician visits performed while inpatient will be covered under the physician benefit with the copay stated in the schedule of benefits.

This is a summary plan only. Its purpose is not to replace complete plan document, but to provide an overview.

Deductible

Type	Network	Non-Network	Limitations
Individual	\$0 – No deductible	\$500	Not applicable

Coinsurance

	100%	40%	Not applicable
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Out-of-Pocket Maximums

Individual Maximum	\$1,850 per covered person, per plan year	No maximum	Copays apply to out-of-pocket. When the out-of-pocket per plan year has been reached, no additional copays will be applied. In-network out-of-pocket separate from non-network out-of-pocket.
Family Maximum	\$12,700 Per covered family, per plan year	No maximum	

Hospital Services

All Inpatient Hospital Services	Not Covered	Not Covered	Includes <u>all</u> services billed by any facility when admitted (stay over 24 hours).
Miscellaneous Charges	Not Covered	Not Covered	Includes inpatient and outpatient miscellaneous services, including but not limited to chemotherapy and infusion.
Outpatient Surgery	Not Covered	Not Covered	Not applicable
Emergency Room (ER)	\$400 copay, then paid at 100%	\$400 copay, then paid at 100%	Copays apply to the network out-of-pocket maximum. Includes <u>all</u> services done in ER. ER services will not be covered if admitted to hospital. One copay for physician and facility per ER visit.
Lab & X-ray: outpatient facility	\$50 copay, then paid at 100%	40% after deductible	Copay will apply per service line billed. Copay applies to the out-of-pocket maximum. Does not include inpatient facility charges. Does not include CT/PET scan and MRIs.

Physician Services

Primary Care Physician (PCP)	\$15 copay, then paid at 100%	40% after deductible	Allowed with copay only for visit for illness or injury. Visit will be allowed for any place of service or location. This benefit does not include services other than visit/exam. Copay applies to the out-of-pocket maximum.
Specialist	\$25 copay, then paid at 100%	40% after deductible	Allowed with copay only for visit for illness or injury. Visit will be allowed for any place of service or location. This benefit does not include services other than visit/exam. Copay applies to the out-of-pocket maximum.
Surgery – in office, outpatient facility, inpatient facility	Not Covered	Not Covered	Not applicable
Medical equipment & supplies	Not Covered	Not Covered	Includes durable medical equipment, prosthetics and general supplies.
Lab & X-ray: in office & non-office outpatient facility	\$50 copay, then paid at 100%	40% after deductible	Copay will apply per service line billed. Copay applies to the out-of-pocket maximum. Does not include inpatient facility charges. Does not include CT/PET Scan and MRIs.
Imaging: CT/PET scan and MRIs	\$400 copay, then paid at 100%	40% after deductible	Copay will apply per service line billed. Copay applies to the out-of-pocket maximum. Does not include inpatient facility charges.
Emergency Room (ER) physician visit	\$400 copay, then paid at 100%	\$400 copay, then paid at 100%	Copays apply to the network out-of-pocket maximum. One copay for physician and facility per ER visit.
Preventive/Wellness	100%	40% after deductible	Limited only to CMS mandated preventive services – See separate plan document for complete listing.

Unless covered under Preventive/Wellness or CDM benefit excludes (but not limited to) services for: maternity care, medical or allergy injections, mental health, substance abuse, durable medical equipment, prosthetics, home health care, hospice, TMJ, specialty/biotech medications, physical therapy, occupational therapy, speech therapy, chiropractic care, infusion therapy, radiation and chemotherapy. See exclusions for complete list.

Prescription Drugs – copays apply toward the medical out-of-pocket

Service	Benefit	Limitations
Generic Drugs	\$15 copay per prescription or refill	Limited to a 34-day supply
Preferred Drugs	\$25 copay per prescription or refill	Limited to a 34-day supply
Non-Preferred Drugs	\$35 copay per prescription or refill	Limited to a 34-day supply
Mail-In Generic Drugs	\$37.50 copay per prescription or refill	Limited to a 90-day supply
Mail-In Preferred Drugs	\$62.50 copay per prescription or refill	Limited to a 90-day supply
Mail-In Non-Preferred Drugs	\$87.50 copay per prescription or refill	Limited to a 90-day supply
Biotech/Specialty Drugs	Not Covered	Not Covered

Chronic Disease Management (CDM) Benefits

The listed chronic diseases below shall have the listed services (service details listed in full plan document) rendered by a network provider payable at 100% and not subject to the copay. Non-network services shall be payable according to the standard plan benefits. Once the service maximum benefit has been met, eligible charges shall be payable according to the standard plan benefits.

The provider must provide the appropriate billing including diagnosis code and procedure/CPT code for the Chronic Disease Management benefit to apply. If a covered person has more than one CDM diagnosis, the primary diagnosis billed will determine the benefit payable.

*The services listed below are the standard laboratory and diagnostic procedure for each disease.

Asthma	2 Office exams per plan year *Spirometry
Atherosclerosis (Peripheral Vascular Disease)	1 Office exam per plan year *Lipid panel
Atrial Fibrillation	1 Office exam per plan year *EKG *Prothrombin times
Chronic Obstructive Pulmonary Disease	2 Office exam per plan year *Spirometry
Chronic Renal Insufficiency	2 Office exam per plan year * Creatinine *Completed blood count (CBC) *Electrolytes *Urine protein *Serum calcium *Serum phosphorus *Lipid panel
Congestive Heart Failure	2 Office exams per plan year *BUN *Creatinine *Potassium
Coronary Artery Disease	1 Office exam per plan year *Lipid panel *EKG *Cholesterol
Diabetes	2 Office exams per plan year *Glycohemoglobins *Microalbumin *Lipid panel
Epilepsy	1 Office exam per plan year
Human Immunodeficiency Virus Infection	1 Office exams per plan year *T-Cell/CD-4 counts *HIV quantifications *Pap smear (women only) *PPD *Complete blood count (CBC)

Hyperlipidemia	1 Office exam per plan year *Lipid panel *Cholesterol
Hypertension	2 Office exams per plan year
Hyperthyroidism	1 Office exam per plan year *Thyroid stimulating hormone (TSH) *Thyroxine (T4)
Hypothyroidism	1 Office exam per plan year *Thyroid stimulating hormone (TSH) *Thyroxine (T4)
Metabolic Syndrome	1 Office exam per plan year *Lipid panel *Glucose FBS or Hemoglobin A1c (HgbA1c)
Multiple Sclerosis	2 Office exams per plan year
Parkinson's Disease	2 Office exams per plan year
Pre-diabetes	1 Office exam per plan year *Lipid panel *Glucose FBS or Hemoglobin A1c (HgbA1c)
Polymyalgia Rheumatica	2 Office exams per plan year *Erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) *Complete blood count (CBC)
Pulmonary Hypertension (unrelated to COPD)	2 Office exams per plan year
COPD with Pulmonary Hypertension/COR Pulmonale	2 Office exams per plan year *Spirometry *12 months of supplemental O2 Tx
Rheumatoid Arthritis	1 Office exams per plan year *Complete blood count (CBC)
Sleep Apnea	1 Office exam per plan year
Chronic Venous Thrombotic Disease	2 Office exams per plan year
Ulcerative Colitis (Inflammatory Bowel Disease)	1 Office exam per plan year *Complete blood count *LFT