## NETWORK HEALTH PLAN BENEFITS NHTA

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Hospice Care Services No charge
Hospice Care Services No charge
Family Planning Complete
Family Planning Services \$20 copayment  Office Visits (tests, counseling)
Vasectomy/Tubal Ligation (excludes reversals)
Infertility Services
Office Visit (Tests, Counseling) \$20 copayment per visit
Hospital charges  No charge
Coverage will be provided for the following services: Testing and treatment services
performed in connection with an underlying medical condition. Testing performed
specifically to determine the cause of infertility. Treatment and/or procedures performed specifically to restore fertility; Artificial Insemination

BENEFIT HIGHLIGHTS (Continued)  TMJ - Surgical and Non-Surgical - case-by-case basis. Always excludes appliances and orthodonic treatment. Subject to medical necessity.  Moretal Health Services Inpatient Outpatient Up to 20 visits per calendar year No charge Up to 20 visits per calendar year Outpatient Supplied to the Color of t		T	
Mental Health Services Inpatient Up to 20 visits per calendar year  Outpatient Services Inpatient Up to 20 days per calendar year  Outpatient Services Up to 20 visits per calendar year  Outpatient Services Up to 20 visits per calendar year  Outpatient Services Up to 20 visits per calendar year  Outpatient Services Up to 55,000 per member per calendar year  No charge  Vision Care Eye exam  Exam Frequency Under age 19 Age 19 and over  Hardware  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment Annual Deductible  None  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  S500 S1,000  S500 S1,000	BENEFIT HIGHLIGHTS (Continued)		
Inpatient No charge Outpatient Up to 20 visists per calendar year Substance Abuse Inpatient Up to 20 days per calendar year Outpatient Services Up to 20 visits per calendar year Outpatient Services Up to 20 visits per calendar year Outpatient Services Up to \$5,000 per member per calendar year  No charge Up to \$5,000 per member per calendar year  No charge  Vision Care Eye exam Exam Frequency Under age 19 Age 19 and over Hardware  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement Annual Deductible  None  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  S500 S1,000 S500		\$20 copayment per visit	
Inpatient No charge Outpatient Up to 20 visists per calendar year Substance Abuse Inpatient Up to 20 days per calendar year Outpatient Services Up to 20 visits per calendar year Outpatient Services Up to 20 visits per calendar year Outpatient Services Up to \$5,000 per member per calendar year  No charge Up to \$5,000 per member per calendar year  No charge  Vision Care Eye exam Exam Frequency Under age 19 Age 19 and over Hardware  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement Annual Deductible  None  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  S500 S1,000 S500	Mental Health Services		
Substance Abuse Inpatient Up to 20 days per calendar year  Outpatient Services Up to 20 visits per calendar year  Durable medical Equipment/External Prosthetic Appliances Up to \$5,000 per member per calendar year  Vision Care Eye exam  No charge  Vision Care Eye exam  Exam Frequency Under age 19 Age 19 and over  Hardware  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family		No charge	
Substance Abuse   Inpatient   Up to 20 days per calendar year   No charge   No charge	Outpatient	No charge	
Substance Abuse   Inpatient   Up to 20 days per calendar year   No charge   No charge	Up to 20 visits per calendar year		
Inpatient Up to 20 days per calendar year  Outpatient Services Up to 20 visits per calendar year  Durable medical Equipment/External Prosthetic Appliances Up to \$5,000 per member per calendar year  Vision Care Eye exam  Exam Frequency Under age 19 Age 19 and over Hardware  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  No charge  No charge  S100 DME/EPA deductible One exam every delendar year One exam every calendar year One exam every two calendar year One exam every two calendar years S100 every two years for each member  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment None  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  \$5,000  \$5,000  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$5,000  \$1,000			
Outpatient Services Up to 20 visits per calendar year  Durable medical Equipment/External Prosthetic Appliances Up to \$5,000 per member per calendar year  Vision Care Eye exam  Exam Frequency Under age 19 Age 19 and over  Hardware  OTHER BENEFIT INFORMATION  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  No charge  No charge  One exam every calendar year One exam every two calendar years  S100 every two years for each member  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment None  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  \$500 \$1,000 \$1,000		No charge	
Up to 20 visits per calendar year  Durable medical Equipment/External Prosthetic Appliances Up to \$5,000 per member per calendar year  Vision Care Eye exam  Exam Frequency Under age 19 Age 19 and over Hardware  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  S500 S1,000 S5,000 S1,000 S1,000 S1,000 S1,000 S1,000 S1,000 S1,000	I · · · ·	To charge	
Durable medical Equipment/External Prosthetic Appliances   Up to \$5,000 per member per calendar year	1	No charge	
Vision Care Eye exam  Exam Frequency Under age 19 Age 19 and over  Hardware  OTHER BENEFIT INFORMATION  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  20% coinsurance  No charge  No charge  One exam every calendar year One exam every two calendar year One exam every two calendar year One exam every two calendary year		\$100 DME/EDA deductible	
Exam Frequency Under age 19 Age 19 and over  Hardware  S100 every two years for each member  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  S1,000 \$2,000  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$500 \$1,000 \$1,000			
Exam Frequency Under age 19 Age 19 and over  Hardware  S100 every two years for each member  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  S1,000  \$1,000  \$500  \$500  \$1,000	Vision Care		
Under age 19 Age 19 and over  Hardware  \$100 every two years for each member  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  \$1,000 \$2,000  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$500 \$1,000	Eye exam	No charge	
Under age 19 Age 19 and over  Hardware  \$100 every two years for each member  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  \$1,000 \$2,000  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$500 \$1,000	Exam Frequency		
Age 19 and over  Hardware  \$100 every two years for each member  OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Deductible  None  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  \$1,000		One exam every calendar year	
OTHER BENEFIT INFORMATION  Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  None  Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  \$1,000 \$2,000  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$500 \$1,000			
Health Club/Equipment Reimbursement  The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment  Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  \$1,000 \$2,000  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$500 \$1,000	Hardware	\$100 every two years for each member	
Annual Deductible  Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$500 \$1,000 \$1,000		The cost of approved Health Club membership up to	
Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family  S1,000 \$2,000  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$500 \$1,000	Treatin Gas/Equipment remisarsement	\$450 per employee or up to \$200 reimbursement for	
Individual Family  \$1,000 \$2,000  Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family  \$500 \$1,000	Annual Deductible	None	
Individual \$500 Family \$1,000	Individual		
Lifetime Maximum None	Individual		
	Lifetime Maximum	None	

All services, except for emergency services, routine vision care, routine care provided by a participating OB/GYN, and Mental Health and Substance Abuse services authorized by the mental health services administrator, must be provided by or authorized by your PCP in order to be covered.

Approved Health Clubs may directly bill the plan administrator for covered benefits.

## **Benefit Exclusions:**

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

- 1. Services that are not medically necessary, except specifically outlined preventive care.
- 2. Charges which the person is not obligated to pay.
- 3. Charges made by a hospital owned by or performing services for the U.S. government if the charges are directly related to a sickness or injury connected to military service.
- 4. Custodial services not intended primarily to treat a specific injury or sickness, or any education or training.
- 5. Experimental, investigational or unproven procedures and treatment.
- 6. Cosmetic surgery or therapy.
- Reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment, insurance or government licenses and court ordered forensic or custodial evaluations.
- 8. Treatment of the teeth or periodontium, unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
- 9. Reversal of voluntary sterilization procedures.
- 10. Certain infertility services.
- 11. Transsexual surgery and related services.
- 12. Treatment for erectile dysfunction. However, penile implants are covered with an established medical condition is the cause of erectile dysfunction.
- 13. Therapy to improve general physical condition.
- 14. Charges for the maintenance and repairs of external prostheses due to misuse.
- 15. Surgical treatment for correction of refractive errors, including radial keratotomy.
- 16. Non-prescription drugs.
- 17. Routine foot care.
- 18. Any injury or sickness arising out of, or in the course of, any employment for wage or profit.
- 19. Charges for consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as provided in the Certificate or Summary Plan Description.
- 20. Charges for medical and surgical services intended primarily for the treatment of control of obesity.
- 21. Speech therapy which is not restorative in nature.
- 22. Artificial aids, including but not limited to orthopedic shoes, arch supports, elastic stockings, dentures.

**Please note:** This list of benefit highlights describes some of the benefits, terms of coverage and exclusions under your network plan. A complete description of the benefits, terms of coverage, exclusions and limitations is provided in the Summary Plan Description.