NETWORK HEALTH PLAN BENEFITS
NHTA

BENEFIT HIGHLIGHTS	
Primary Care Physician (PCP) Office Visit Preventive Care for children and adults Immunizations Medical Care for Illness or Injury Surgery Performed in the Physician's Office	 No charge No charge $10 copayment per visit $10 copayment per visit
Routine Mammograms, PSA, Pap Test	No charge
Specialty Physician Office Visit Office Visits: Consultant and Referral Physician Services Allergy Treatment/Injections Surgery Performed in the Physician's Office	 $20 copayment per visit No charge $20 copayment per visit
Inpatient Hospital Services – includes Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Inpatient Hospital Doctor's Consultations	No charge
Outpatient Facility Services Operating and Recovery Room Diagnostic/Therapeutic Lab and X-ray Physician & Outpatient Professional Services	No charge
Laboratory and Radiology Services MRIs, CAT Scans and PET Scans Other Laboratory and Radiology Services Outpatient Hospital Facility Independent X-Ray and/or Lab Facility	No charge
Short-Term Rehabilitative Therapy Includes: cardiac, physical, speech and occupational therapy	No charge
Chiropractic Services (PCP referral not required for chiropractic care) 20 visits maximum per calendar year	No charge
Prescription Drugs Retail (per 31 day supply) Generic drugs Formulary brand drugs Non-formulary drugs Mail Order Drug: generic, formulary brand, or non-formulary (per 90 day supply)	 $10 copayment $20 copayment $35 copayment 2 x the applicable 31 day copayment
Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician Hospital Emergency Room/Urgent Care Facility Ambulance	 $10 copayment per visit to PCP, $20 copayment per visit to Specialty Physician $50 copayment per visit (copay waived if admitted or if referred by PCP or treating physician) No charge
Inpatient Services at Other Health Care Facilities Skilled Nursing and Rehabilitation (up to 100 days per calendar year combined)	No charge
Maternity Care Services Initial Visit to confirm pregnancy Office Visits Delivery Hospital Charges Physician Charges	 $10 No charge No charge
Home Health Services	No charge
Hospice Care Services	No charge
Family Planning Services Office Visits (tests, counseling) Vasectomy/Tubal Ligation (excludes reversals)	$20 copayment
Infertility Services Office Visit (Tests, Counseling) Hospital charges 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	 $20 copayment per visit No charge

BENEFIT HIGHLIGHTS (Continued)	
TMJ - Surgical and Non-Surgical – case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity.	$20 copayment per visit
Mental Health Services Inpatient Outpatient Up to 20 visits per calendar year	 No charge No charge
Substance Abuse Inpatient Up to 20 days per calendar year Outpatient Services Up to 20 visits per calendar year	 No charge No charge
Durable medical Equipment/External Prosthetic Appliances Up to $5,000 per member per calendar year	$100 DME/EPA deductible 20% coinsurance
Vision Care Eye exam Exam Frequency Under age 19 Age 19 and over Hardware	 No charge One exam every calendar year One exam every two calendar years $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 $2,000
Annual Out-of-Pocket Maximum (OOPM) for all other medical costs Individual Family	 $500 $1,000
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.
7. 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.