POINT OF SERVICE HEALTH PLAN BENEFITS
NHTA

BENEFIT HIGHLIGHTS	In network benefits	Out of network benefits
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 per visit $10 per visit	 80%* No charge 80%* 80%*
Routine Mammograms, PSA, Pap Test	No charge	No charge
Specialty Physician Office Visit Office Visits: Consultant and Referral Physician Services Allergy Treatment/Injections Surgery Performed in the Physician's Office	 $20 per visit No charge $20 per visit	 80%* 80%* 80%*
Inpatient Hospital Services – includes Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Inpatient Hospital Doctor's Visits/Consultations	No charge	80%*
Outpatient Facility Services Operating and Recovery Room Diagnostic/Therapeutic Lab and X-ray Physician & Outpatient Professional Services	 No charge No charge No charge	 80%* 80%* 80%*
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 No charge No charge	 80%* 80%* 80%*
Short-Term Rehabilitative Therapy (includes cardiac rehab, physical, speech and occupational therapy) up to $3,000 per calendar year for all therapies combined	No charge	80%*
Chiropractic Services 20 visits maximum per calendar year	No charge	80%*
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	 n/a
Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician Hospital Emergency Room/Urgent Care Facility Ambulance (If not a true emergency, emergency care services not covered)	 $10 per visit to PCP, $20 per visit to Specialty Physician $50 copayment per visit (copay waived if admitted or if referred by PCP or treating physician) No charge	 $10 per visit to PCP, $20 per visit to Specialty Physician $50 copayment per visit (copay waived if admitted or if referred by PCP or treating phsyician) No charge
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation and Sub-Acute Facilities 30 days combined maximum per calendar year	No charge	80%*
Maternity Care Services Initial Office Visit to Confirm Pregnancy All other office visits Delivery Hospital Charges Physician Charges	 $10 No charge No charge No charge	 80%* 80%* 80%* 80%*
Home Health Services	No charge	80%*
Hospice Care Services	No charge	80%*
Family Planning Services Office Visits (tests, counseling) Vasectomy/Tubal Ligation (excludes reversals)	 $20 per visit	 80%* 80%*

BENEFIT HIGHLIGHTS (Continued)	In network benefits	Out of network benefits
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 per visit No charge	 80%* 80%*
TMJ - Surgical and Non-Surgical – case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Physician's Office Hospital Charges	 $20 per visit No charge	 80%* 80%*
Mental Health Services Inpatient Outpatient	 No charge No charge	 80%* 80%*
Substance Abuse Services-limited to $5,000 per calendar year, and limited to $10,000 per lifetime Inpatient Outpatient Services	 No charge No charge	 80%* 80%*
Durable medical Equipment/External Prosthetic Appliances	 No charge	 $100 deductible per member then 80%
Vision Care Eye exam Exam Frequency Under age 19 – limited to one exam every calendar year Age 19 and over – limited to one exam every two calendar years	 No charge	 80%*
Annual Deductible Individual Family	 None None	 $150 $450
Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family	 $1,000 $2,000	 n/a
Annual Out-of-Pocket Maximum (OOPM) for all other medical costs** Individual Family	 $500 $1,000	 $900 $2,700
Coinsurance	No (except where noted above)	80% where noted

*Deductibles apply

**Credits toward the in-network OOPM accrue separately from credits toward the out-of- network OOPM

All out of network services limited to reasonable & customary limitations

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. Eyeglasses, hearing aids or examinations and prescriptions fitting, except as provided in the Certificate or Summary Plan Description.
15. Charges for the maintenance and repairs of external prostheses due to misuse.
16. Surgical treatment for correction of refractive errors, including radial keratotomy.
17. Prescription and non-prescription drugs, except as provided in the Certificate or Summary Plan Description.
18. Routine foot care.
19. Any injury or sickness arising out of, or in the course of, any employment for wage or profit
20. 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.
21. Charges in excess of reasonable and customary limitations.
22. Charges for medical and surgical services intended primarily for the treatment of control of obesity.
23. Speech therapy which is not restorative in nature.
24. Artificial aids, including but not limited to orthopedic shoes, arch supports, elastic stockings, dentures and wigs.

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