

Select Coverage

Deductibles and Coinsurance Maximums for Medical Services

	IN-NETWORK	OUT-OF-NETWORK
Individual Calendar Year Medical Deductible	\$1,000	\$2,000
Family Calendar Year Medical Deductible	\$2,000	\$4,000
Individual Medical Coinsurance Maximum	\$2,500	\$3,500
Individual Prescription Drug Deductible	\$75	

Individual Calendar Year Medical Deductible

The calendar year medical deductible is the amount of covered medical expense a participant must pay each year before the Plan begins to pay its share of covered medical expenses. Once the calendar year deductible is met, the Plan pays a percentage of the allowable charge for covered medical expenses.

The initial \$1,000 of covered medical expense will apply to both the in and out-of-network deductible. After the initial \$1,000 has been applied, only services rendered by a non-participating provider will be applied to the additional \$1,000 out-of-network deductible.

The following expenses do not count towards the calendar year medical deductible:

- Prescription drug deductible
- Expenses in excess of the allowable charge
- Expenses in excess of Plan maximum limits
- Services not considered medically necessary
- Emergency room co-payment
- Prescription drug co-payments
- Utilization review penalties
- Private room co-payment
- Services not covered by the Plan

Family Calendar Year Medical Deductible

Once a family has paid the family medical deductible in a calendar year, all covered participants in that family will have satisfied their individual medical deductibles for that calendar year. The family medical deductible also applies when both husband and wife are covered separately as enrollees and both are enrolled in Select Coverage. No individual family member may contribute more than \$1,000 to the in-network family medical deductible or more than \$2,000 to the out-of-network family medical deductible.

The initial \$2,000 of covered expense will apply to both the in and out-of-network family medical deductible. After the initial \$2,000 has been applied, only services rendered by a non-participating provider will be applied to the additional \$2,000 out-of-network family medical deductible.

Coinsurance

Once a participant has met the calendar year medical deductible, the Plan pays a portion of the allowable charge for covered medical expenses. The participant pays the remainder in the form of coinsurance.

Any fees charged by a non-participating provider that are above the allowable charge are not part of the coinsurance amount. The Plan will not pay any portion of these charges.

Helpful Tip: Participating providers agree not to charge any amount above the Plan’s allowable charge for covered services.

Individual Medical Coinsurance Maximum

The medical coinsurance maximum is the maximum amount that each participant has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100%. The medical coinsurance maximum protects a participant from having to pay catastrophic medical bills in a given year. The amount paid toward meeting the calendar year individual and family medical deductibles does not count toward satisfying the medical coinsurance maximum.

The initial \$2,500 of medical coinsurance is applied to both the in and out-of-network medical coinsurance maximum. After the initial \$2,500 has been met, only the coinsurance amount for services rendered by non-participating providers will be applied to the additional \$1,000 out-of-network coinsurance. Once the annual medical coinsurance maximum is met, the Plan covers 100% of the allowable charge for covered medical expenses for the remainder of that calendar year, except as otherwise specified. Each individual participant must meet their medical coinsurance maximum before benefits are paid at 100%; there is no family medical coinsurance maximum. The Plan will never pay 100% for those expenses that do not apply toward satisfying the coinsurance maximum.

Do These Expenses Count Towards The Coinsurance Maximum?	
YES	NO
<ul style="list-style-type: none">▪ The coinsurance paid for hospital inpatient services▪ The coinsurance paid for other covered medical expenses	<ul style="list-style-type: none">▪ The calendar year deductibles▪ The family deductibles▪ The prescription drug deductible▪ Expenses in excess of the allowable charge▪ Expenses in excess of Plan maximum limits▪ Utilization review penalties▪ Services not covered by the Plan including all those found in the <i>Medical Limitations and Exclusions</i> section▪ Prescription drug co-payments

Do These Expenses Count Towards The Coinsurance Maximum?	
YES	NO
	<ul style="list-style-type: none"> ▪ Generic drug differential amounts ▪ Services not considered medically necessary ▪ The private room co-payment ▪ The emergency room co-payment

Individual Prescription Drug Deductible

Before the Plan will pay any of the cost for prescription drugs, each participant must first satisfy a \$75 prescription drug deductible each calendar year.

The prescription drug deductible and co-payment amounts will not apply toward satisfying the medical calendar year deductible or coinsurance maximum.

Summary of Select Coverage Medical Benefits

This is only a summary of the medical benefits under Select Coverage. It does not provide all details and provisions of the Plan. Some limitations and exclusions apply and can be found within this *Plan Document*.

	In-Area Participants		Out-of-Area Participants	
	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual Calendar Year Medical Deductible	\$1,000	\$2,000	\$1,000	\$2,000
Family Calendar Year Medical Deductible	\$2,000	\$4,000	\$2,000	\$4,000
Individual Medical Coinsurance Maximum	\$2,500	\$3,500	\$2,500	\$3,500
All benefits are subject to the medical deductibles unless otherwise noted in the Covered Services section.				
Physician Services	80%	60%	80%	75%
Hospital – In-patient*	80%	60%	80%	75%
Hospital – Out-patient	80%	60%	80%	75%
Emergency Room	80%	60%	80%	75%
X-Rays, Laboratory	80%	60%	80%	75%
Adult Wellness/Preventive Services	100%	Not Covered	100%	100%
Maternity – Attending Physician	100%	90%	100%	90%
Maternity – Hospital*; Other Services	80%	60%	80%	75%
Ambulatory Surgical Facility	80%	60%	80%	75%
Cardiac Rehabilitation (outpatient)	80%	60%	80%	75%
Chiropractic Services	80%	60%	80%	75%
Durable Medical Equipment	80%	60%	80%	75%
Home Infusion Therapy*	80%	60%	80%	75%
Hospice Care Services*	80%	60%	80%	75%
Long Term Acute Care Facility*	80%	60%	80%	75%
Mental Health				
Inpatient*	80%	60%	80%	75%
Outpatient	80%	60%	80%	75%
Day Treatment	80%	60%	80%	75%
Partial Hospitalization	80%	60%	80%	75%
Residential Treatment*	80%	60%	80%	75%
Nurse Practitioner	80%	60%	80%	75%
Occupational Therapy	80%	60%	80%	75%
Optometric Services	80%	60%	80%	75%
Organ Transplants*	80%	60%	80%	75%
Physical Therapy	80%	60%	80%	75%
Private Duty and Home Health Nursing Services*	80%	60%	80%	75%

	In-Area Participants		Out-of-Area Participants	
	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Skilled Nursing Facility*	80%	60%	80%	75%
Sleep Disorders	80%	60%	80%	75%
Speech Therapy	80%	60%	80%	75%
Substance Abuse				
Inpatient*	80%	60%	80%	75%
Outpatient	80%	60%	80%	75%
Intensified Outpatient	80%	60%	80%	75%
Residential Treatment*	80%	60%	80%	75%
Well-Newborn Nursery Care	100%	Not Covered	100%	75%
Well-Child Physician Office Visits	100%	Not Covered	100%	100%
Well-Child Specified Routine Tests	100%	Not Covered	100%	100%
Well-Child Routine Immunization	100%	Not Covered	100%	100%

**Services must be certified as medically necessary by ActiveHealth to be covered by the Plan.*

Additional Benefits

Coverage for the services listed below is subject to the in-network calendar year medical deductibles and the individual medical coinsurance maximum of \$2,500. These services are not eligible for an out-of-network review.

Benefit	In-Area Participants		Out-of-Area Participants	
	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Accidental Injury to Natural Teeth	80%	75%	80%	75%
Anesthesia	80%	75%	80%	75%
Podiatry Services	80%	75%	80%	75%
Ambulance	80%	75%	80%	75%
Medical Supplies	80%	75%	80%	75%
Prosthetic and Orthotic Procedures and Devices	80%	75%	80%	75%
TMJ	80%	75%	80%	75%