



NEW WEST HEALTH PLAN

GROUP BASIC PLAN OUTLINE OF COVERAGE AND SCHEDULE OF BENEFITS

(New West Health Plan is referred to below as "NWHP.")

Outline of Coverage

GENERAL BENEFIT INFORMATION

Your benefits booklet, any applicable endorsements and the following schedule of benefits describe the benefits and coverage provided under this plan. Generally, your coverage includes benefits for emergency care, urgent care, provider office visits, hospital care (inpatient and outpatient), maternity/pregnancy care, sterilization, durable medical equipment, oxygen, diabetic health care services (including foot care), convalescent care (skilled nursing care), anesthetics, radium and other radioactive materials, prosthetics and orthotics, therapies and preventive, screening and diagnostic medical testing (x-rays and laboratory).

You are responsible for paying:

- Deductible,
- Coinsurance/Copayment,
- Expenses up to the maximum out-of-pocket amount,
- Amounts that exceed benefit limitations, including the lifetime benefit maximum,
- Costs for non-covered services, and
- **Costs for services by non-participating providers**, except in certain circumstances (such as emergency care).

PREMIUM DETERMINATION AND COSTS

Small group premiums are developed based upon our entire small group population (i.e., pooled with the rest of NWHP's small group business for rating purposes). Certain characteristics of the group are factored into the rating process, such as demographics, geographic factors, and risk characteristics. Large group premiums are generally developed based upon a combination of claims/utilization, demographics, geographic factors, industry, risk, etc. They may be pooled with other groups of similar size.

The premium trend during the preceding 5 years, to the extent such data is available, reflects that premiums have increased by an average of about 9.5% per year.

Schedule Of Benefits (In-Network)

IN-NETWORK SERVICES

MEMBER PAYS

DEDUCTIBLE & COINSURANCE APPLY TO ALL COVERED SERVICES UNLESS SPECIFICALLY STATED OTHERWISE IN THIS SCHEDULE OF BENEFITS, ENDORSEMENTS OR THE BENEFITS BOOKLET.

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| Deductible | \$750 per member per contract year. \$1,500 per family per contract year. |
| Coinsurance | 40% of allowed charges after the deductible has been paid, unless otherwise stated in this Schedule of Benefits. |
| Out-of-Pocket Maximum | \$4,000 per member per contract year. \$6,000 per family per contract year. Only deductible and coinsurance apply to the out-of-pocket maximum. |
| Prescription Drugs | 50% of allowed charges after deductible. |
| Chiropractic Care | \$20 copayment per office visit. The cost of procedures and/or screening and/or diagnostic medical testing performed at the time of the office visit are subject to deductible and coinsurance. |

IN-NETWORK SERVICES

NWHP PAYS

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| Lifetime Benefit Maximum | \$2,000,000 per member. |
| Coinsurance | 60% of allowed charges after the deductible, unless otherwise stated in this Schedule of Benefits. |
| Prescription Drugs | 50% of allowed charges after deductible. |
| Diabetic Self-Management Training & Education | 100% of the first \$250 of outpatient covered services per contract year. No benefits will be paid for these health care services once the \$250 benefit has been paid. |
| Mammography | 100% of allowed charges. Deductible waived. |
| Routine Newborn Exam | 60% of allowed charges for all covered services. Deductible waived. (Generally, performed before discharge from the hospital following birth.) |
| Surgery | 60% of allowed charges after you pay the deductible for all covered services subject to coinsurance. (This includes oral surgery for the gums and tissue of the mouth when <u>not</u> performed in connection with the extraction or repair of teeth or in connection with TMJ.) |
| Well Child Care (Birth through 17 years of age) | 60% of allowed charges for all covered services. Deductible is waived from birth through age two. See the benefits booklet for well child visit frequency limits. |

ANNUAL BENEFIT MAXIMUMS

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| Alcoholism and Drug Addiction Health Care Services | \$6,000 annual benefit maximum for inpatient and outpatient covered services combined. After \$12,000 in allowed charges for inpatient services, \$2,000 annual benefit maximum for inpatient and outpatient covered services combined. |
| Cataract Surgery-Related Eyeglass Lenses & Contacts | One pair of eyeglass lenses or contacts, up to a \$250 benefit maximum per surgery. |
| Chiropractic Services | 15 visits annual benefit maximum. |
| Durable Medical Equipment | \$3,000 annual benefit maximum combined with Orthotics. (Not applicable to diabetic insulin pumps.) |
| Home Health Care Services | 180 visits annual benefit maximum. |
| Mental Illness Health Care Services | Inpatient: 21 inpatient days or 42 partial inpatient days annual benefit maximum. Outpatient: 30 visits annual benefit maximum. Annual benefit maximums do not apply to health care services to treat severe mental illness. |
| Orthotics | \$3,000 annual benefit maximum combined with Durable Medical Equipment. |
| Prescription Drugs | \$2,000 annual benefit maximum. |
| Skilled Nursing Facility | 60 days annual benefit maximum. |
| Sleep Apnea | \$500 annual benefit maximum for oral device and related health care services. |
| Outpatient Physical Therapy, Speech Therapy & Occupational Outpatient Cardiac Rehabilitation, Pulmonary Rehabilitation Therapy | 30 visits combined annual benefit maximum. |
| Transplants | <p>\$500,000 lifetime benefit maximum*, which includes certain donor expenses up to \$10,000. Must be at a facility designated by NWHP as a transplant center of excellence.</p> <p>High-dose chemotherapy bone marrow transplantation is a covered service if the transplant is <u>not</u> experimental and/or investigational. The exclusion in the benefits booklet for such transplants <u>does not</u> apply to this plan.</p> <p>*Transplant-related travel expenses: \$5,000 lifetime maximum benefit maximum per transplant; copayments, deductibles and/or coinsurance do not apply.</p> |

GENERAL EXCLUSIONS AND LIMITATIONS

Certain health care services are not covered services, including, but not limited to:

- Out-of-network services.
- Any health care services that are not medically necessary and appropriate or are only for the convenience of you, your family or caregivers, or your physician, or any charge made solely because you are covered by NWHP. Health care services for pre-existing conditions or for complications or side effects arising from, or reversal of, health care services excluded or not otherwise covered.
- Health care services received prior to or after termination of coverage.

GENERAL EXCLUSIONS AND LIMITATIONS (CONTINUED)

- Health care services provided by or through free clinics or government free programs, or paid for by a charity.
- Dental services, unless the plan has a dental rider or as otherwise stated in the benefits booklet.
- Vision care, unless the plan has a vision rider or as otherwise stated in the benefits booklet.
- Charges for missed or cancelled appointments.
- Health care services for conditions, diseases, illnesses or bodily injuries that occur in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of workers' compensation laws or other legislation.
- Cosmetic services.
- Experimental/investigational health care services, including, but not limited to, experimental drugs, diets and other health care services that are not accepted medical practice.
- Alternative, unconventional, holistic or complementary medicine services.
- Any health care services that exceed benefit limits or maximums or are specifically listed in the benefits booklet, any applicable riders or this schedule of benefits as excluded. You are responsible and liable for 100% of billed charges for non-covered services.

It is your responsibility to obtain any required authorization. Failure to obtain authorization for health care services for which written authorization by NWHP is required may result in benefits being denied. Refer to the benefits booklet for a list of health care services that require authorization.

Also see the Benefits Booklet & Any Applicable Endorsements for a Listing of Covered Services, Exclusions & Limitations.

If you need more information or have any questions about our health care programs, please contact Customer Services at 1-800-290-3657.

www.newwesthealth.com