



## Health Connections

### 100 / \$5,000 Group Indemnity Plan

#### OUTLINE OF COVERAGE AND SCHEDULE OF BENEFITS

*This Group Plan utilizes the Group Member Certificate Benefits Booklet.*

#### Outline of Coverage

NEW WEST HEALTH SERVICES IS REFERRED TO BELOW AS "NWHS."

##### GENERAL BENEFIT INFORMATION

Your benefits booklet, any applicable endorsements and the following schedule of benefits describe the benefits and coverage provided under this Health Connections plan. Generally, your coverage includes benefits for emergency care, urgent care, provider office visits, hospital care (inpatient and outpatient), durable medical equipment, prosthetics, orthotics, therapies, preventive, screening and diagnostic medical testing.

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
- Amounts that exceed NWHS' allowed charges for non-participating providers

##### BENEFIT DIFFERENTIALS WHEN USING NON-PARTICIPATING PROVIDERS

**It is always to your benefit to use a participating provider. Benefits for out-of-network services will always be lower than benefits for in-network services.** The allowed charge for a health care service provided by a non-participating provider is 10% less than the allowed charge for the same health care service when provided by a participating provider. Also, a provider's billed charge for a given health care service may be significantly greater than the allowed charge for that service. You are not responsible for paying this difference if you use a participating provider. However, you may be required to pay this difference if you use a non-participating provider.

This Group Plan utilizes the **Health Connections Provider Network**.

##### PREMIUM DETERMINATION AND COSTS

Small group premiums are developed based upon our entire small group population (i.e., pooled with the rest of NWHS' 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 11% per year.

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## Schedule of Benefits

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

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### MEMBER PAYS

#### Deductible:

- \$5,000 per member per calendar year.
- \$10,000 per family per calendar year.

#### Coinsurance:

- 0% of allowed charges after you pay the deductible for all covered services subject to coinsurance.

#### Out-of-Pocket Maximum:

- \$5,000 per member per calendar year.
- \$10,000 per family per calendar year.

Only deductible and coinsurance apply to the out-of-pocket maximum. Durable Medical Equipment, Orthotics and Prosthetics health care services do not apply to the out-of-pocket maximum.

#### Emergency Room Surcharge:

- \$50 per member per visit, in addition to applicable deductible and/or coinsurance. (Waived if admitted to the hospital directly from the emergency room.)

#### Well Child Care (birth through 7 years of age):

- \$20 copayment per office visit (includes certain preventive medical testing and immunizations). For current recommended schedule, please contact Customer Service at 800-290-3657.

#### Preventive and Screening Services (age 8 to adult):

- \$20 copayment per office visit based on age appropriate recommendations and many are limited to one per calendar year\* or 0% of allowed charges for a preventive physical examination received from a non-participating provider. For current recommended schedule and list of current preventive services, please contact Customer Service at 800-290-3657.

\*NWHS pays 100% of allowed charges for the visit less your copayment. Costs of procedures and/or screening and/or diagnostic medical testing performed at the time of the office visit are subject to deductible and coinsurance.

### NWHS PAYS

#### Coinsurance:

- 100% of allowed charges after you pay the deductible for all covered services subject to coinsurance.

#### Lifetime Benefit Maximum:

- \$2,000,000 per member.

#### Accident Benefit:

- 100% of the first \$600 of allowed charges for accident-related health care services per calendar year. Deductible and/or coinsurance apply to any additional accident-related health care services. An accident report is required to receive this benefit. Benefits with a set limit and/or maximum are excluded.

#### Diabetic Self-Management Training and Education:

- 100% of the first \$250 of outpatient covered services per calendar year. No benefits will be paid for these health care services once the \$250 benefit has been paid.

**PREVENTIVE AND  
SCREENING SERVICES**

**Voluntary Sterilization:**

- 100% of the first \$300 of allowed charges for covered services for vasectomies, tubal ligations and other forms of permanent sterilization; the rest of the allowed charges will be subject to deductible and coinsurance. This benefit is payable only once per lifetime.

NWHS PAYS WITH DEDUCTIBLE WAIVED

**Routine Newborn Exam:**

- 100% of allowed charges. (Generally performed before discharge from the hospital following birth.)

**Well Child (birth through age 7) & Preventive and Screening Services (age 8 to adult):**

- See **Member Pays** section above.

**Routine Immunizations:**

- 100% of allowed charges. Child and adult (flu, Gardasil, etc.).

**Breast Cancer Screening and Mammography:**

- 100% of allowed charges for a baseline or diagnostic mammogram.  
\*Your Breast Cancer Screening/Mammography benefit includes, but is not limited to, the \$70 State required mandated benefit and is payable at 100% of allowed charges by NWHS.

**Cervical Cancer Screening:**

- 100% of allowed charges.

**Colorectal Cancer Screening:**

- **\$1,300 annual benefit maximum.** Colonoscopy (every 10 years), or Barium Enema (every 5 years), or Sigmoidoscopy (every 5 years), and/or Fecal Occult Blood Testing (FOBT) annually.

**Prostate Cancer Screening:**

- 100% of allowed charges. Rectal examination and Prostate Specific Antigen (PSA) testing.

**Cholesterol and Lipid Disorder Screening:**

- 100% of allowed charges.

**ANNUAL BENEFIT  
MAXIMUMS**

APPLY ON A CALENDAR YEAR BASIS, UNLESS OTHERWISE NOTED BELOW.

**Alcohol and Drug Addiction Health Care Services:**

- \$6,000 annual benefit maximum for inpatient and outpatient covered services combined. After reaching \$12,000 lifetime maximum in allowed charges for inpatient services, \$2,000 annual benefit maximum for inpatient and outpatient covered services combined (does not apply to inpatient detoxification treatment).

**Cataract Surgery-Related Eyeglass Lenses & Contacts:**

- One pair of eyeglass lenses or contacts, up to a \$250 benefit maximum per surgery.

**Chiropractic Services:**

- \$500 annual benefit maximum (including x-rays).

**Durable Medical Equipment:**

- \$5,000 annual benefit maximum combined with Orthotics. (Not applicable to diabetic insulin pumps.)

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**Home Health Care Services:**

- 60 days annual maximum benefit.

**Mental Illness Health Care Services:**

- Inpatient: 21 inpatient days or 42 partial inpatient days annual benefit maximum. Outpatient: \$2,000 annual benefit maximum. Annual benefit maximums do not apply to health care services to treat severe mental illness.

**Orthotics:**

- \$5,000 annual benefit maximum combined with Durable Medical Equipment.

**Outpatient Cardiac Rehabilitation & Pulmonary Rehabilitation Therapy:**

- 15 visits combined annual maximum benefit.

**Outpatient Physical Therapy, Speech Therapy & Occupational Therapy:**

- 30 visits combined annual maximum benefit.

**Prosthetic Devices:**

- \$3,000 annual benefit maximum. (Not applicable to breast prostheses following a mastectomy.)

**Skilled Nursing Facility:**

- 60 days annual benefit maximum.

**Sleep Apnea:**

- \$500 annual benefit maximum for oral device and related health care services.

**Transplants:**

- \$500,000 lifetime benefit maximum\*. Must be at a facility designated by NWHS as a transplant center of excellence.  
\*Transplant-related travel expenses: \$5,000 benefit maximum per transplant. Copayments, deductibles and/or coinsurance do not apply to transplant-related travel. \$10,000 benefit maximum per transplant for surgery, storage and transportation of the human organ used in the transplant.

**GENERAL EXCLUSIONS  
AND LIMITATIONS**

REFER TO "GENERAL EXCLUSIONS AND LIMITS" IN YOUR BENEFITS BOOKLET. ALSO SEE THE BENEFITS BOOKLET AND ANY APPLICABLE ENDORSEMENTS FOR A LISTING OF COVERED SERVICES, EXCLUSIONS, AND LIMITATIONS.

**WANT MORE  
INFORMATION?**

If you have any questions about our health care programs,  
please contact Customer Service at:

**1-800-290-3657**

**[www.newwesthealth.com](http://www.newwesthealth.com)**