New West Select
$5,000 Deductible Group 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 New West Select 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
- 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 **New West 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.

Schedule of Benefits

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

MEMBER PAYS

Deductible:

- $5,000 per member per contract year.
- $10,000 per family per contract year.

Coinsurance:

- No coinsurance.

Out-of-Pocket Maximum:

- $5,000 per member per contract year.
- $10,000 per family per contract year.

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

NWHS PAYS

Coinsurance:

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

Lifetime Benefit Maximum:

- $2,000,000 per member.

Diabetic Self-Management Training and 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.

First Dollar Coverage Benefit:

- Deductible waived for the first $750 of allowed charges each contract year for:
  - Office visits to physicians, mid-level providers, chiropractors, and urgent care facilities.
  - Basic lab and x-rays associated with preventive office visits.
  - Covered services to treat an accidental injury.

  NOTE: Does not apply to emergency room visits, inpatient hospitalization, therapy sessions of any kind, or diagnostic or complex lab or radiology, except when due to accidental injury. In addition, it excludes separately listed benefits on this Schedule of Benefits, such as breast cancer screening and mammography, colorectal cancer screening and well child care.

PREVENTIVE AND SCREENING SERVICES

Routine Newborn Exam:

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

Well Child (birth through 7 years of age):

- 100% of allowed charges for office visits (includes certain preventive medical testing and immunizations.) Deductible is waived.

  For current recommended schedule, please contact Customer Service at 800-290-3657.

Age 8 to Adult:

- 100% of allowed charges (includes certain preventive medical testing and immunizations based on age-appropriate recommendations and many are limited to one per contract year). For current recommended schedule, please contact Customer Service at 800-290-3657. Applies to First Dollar Coverage Benefit.

Routine Immunizations:

- 100% of allowed charges from birth through age 7 with deductible waived. Age 8 to adult, applies to First Dollar Coverage Benefit. Routine immunizations such as flu, Gardisil, etc., for children and adults.

Breast Cancer Screening and Mammography*:

- 100% of allowed charges for a baseline or diagnostic mammogram. Deductible is waived.

  *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. Applies to First Dollar Coverage Benefit.

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. Deductible is waived.

Prostate Cancer Screening:

- 100% of allowed charges. Rectal examination and Prostate Specific Antigen (PSA) testing. Applies to First Dollar Coverage Benefit.

Cholesterol and Lipid Disorder Screening:

- 100% of allowed charges. Applies to First Dollar Coverage Benefit.

ANNUAL BENEFIT MAXIMUMS

APPLY ON A CONTRACT 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.)

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 implants 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