



## Valcare Plan

### OUTLINE OF COVERAGE AND SCHEDULE OF BENEFITS

*This Group Plan utilizes the Group Evidence of Coverage Benefits Booklet.*

#### Outline of Coverage

NEW WEST HEALTH PLAN IS REFERRED TO BELOW AS "NWHP."

#### 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), 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
- Costs for services by non-participating providers, except in certain circumstances (such as emergency care)

If the plan has a point-of-service endorsement, NWHP will pay the allowed charges for covered services rendered by a non-participating provider less any copayments, deductibles and/or coinsurance specified in the plan's schedule of benefits and point-of-service endorsement. You are responsible for all amounts that exceed NWHP's allowed charges.

This Group Plan utilizes the **New West Provider Network**.

#### IMPORTANT INFORMATION ON OUT-OF-NETWORK BENEFITS

**It is always to your benefit to use a participating provider.** A non-participating (out-of-network) provider's billed charge for a given health care service may be significantly greater than the NWHP allowed charge for that service. If the plan does not have a point-of-service endorsement, you are responsible for the entire amount charged by the non-participating provider. If the plan has a point-of-service endorsement, in addition to applicable copayments, deductibles and/or coinsurance you are responsible for paying the difference between the non-participating provider's billed charge and NWHP's allowed charge.

#### 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 11% per year.

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## Schedule of Benefits (In Network)

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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 (IN-NETWORK SERVICES)

#### Deductible:

- \$500 per member per contract year.
- \$1,000 per family per contract year.

#### Coinsurance:

- 30% of allowed charges after the deductible has been paid.

#### Out-of-Pocket Maximum:

- \$2,000 per member per contract year.
- \$4,000 per family per contract 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.

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

- \$20 copayment per office visit (includes certain preventive medical testing and immunizations based on age appropriate recommendations and many are limited to one per calendar year\*). For current recommended schedule and list of current preventive services, please contact Customer Service at 800-290-3657.

#### Routine Pre-Natal Office Visits:

- No copayment for routine pre-natal office visits, except for \$20 copayment for visit in which the provider diagnoses the pregnancy. Deductible and coinsurance apply to:
  - The cost of procedures and/or screening and/or diagnostic medical testing performed at the time of the office visit.
  - Global pre-natal, delivery and post-partum charges.

#### Chiropractic Care:

- \$20 copayment per office visit.\*

#### Other Provider Office Visits:

- \$20 copayment per office visit.\* (Does not include mental health treatments.)

#### Urgent Care Facilities:

- \$20 copayment per office visit.\*

#### Emergency Room:

- \$50 copayment per visit.\* (Copayment waived if admitted to the hospital directly from the emergency room.)

#### Ambulance:

- \$100 copayment per trip. (If multiple ambulances are required to transport you, multiple copayments will be due.)

\* NWHP 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.

**NWHP PAYS**  
(IN-NETWORK SERVICES)

**Lifetime Benefit Maximum:**

- \$2,000,000 per member.

**Coinsurance:**

- 70% of allowed charges after you pay the deductible for all covered services subject to coinsurance.

**Accident Benefit:**

- 100% of the first \$600 of allowed charges for accident-related health care services per contract 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 contract year. No benefits will be paid for these health care services once the \$250 benefit has been paid.

**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.

**PREVENTIVE AND  
SCREENING SERVICES**

**NWHP 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/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 NWHP.

**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.

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**ANNUAL BENEFIT  
MAXIMUMS**

**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 \$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 benefit maximum.

**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.

**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.

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

- 30 visits combined annual benefit maximum.

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

- 15 visits combined annual benefit maximum.

**Transplants:**

- \$500,000 lifetime benefit maximum\*. Must be at a facility designated by NWHP 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)