HEWT GroupHealth Options Medical Plan

EFFECTIVE 1/1/2014

Benefits	Inside Network	Out-of-Network
Plan Deductible—Per Calendar Year (PCY)	Individual deductible: $150 Family deductible: $300	Individual deductible: $250 Family deductible: $500
Individual Deductible Carryover	4th quarter carryover applies.	4th quarter carryover applies.
Plan Co-insurance	Plan pays 80%, you pay 20%.	Plan pays 70%, you pay 30% of the Usual, Customary and Reasonable (UCR) charges.
Out-Of-Pocket Limit	Individual out-of-pocket limit: $1,150 Family out-of-pocket limit: $2,300	Individual out-of-pocket limit: $2,875 Family out-of-pocket limit: $5,750
Pre-existing Condition (PEC) Waiting Period	No waiting period for a PEC.	No waiting period for a PEC.
Lifetime Maximum	Unlimited.	Unlimited.
Outpatient Services (Office Visits)	No co-pay. Deductible and co-insurance apply.	No co-pay. Deductible and co-insurance apply.
Hospital Services	**Inpatient Services:** Deductible and co-insurance apply. **Outpatient Surgery:** No co-pay. Deductible and co-insurance apply.	**Inpatient Services:** Deductible and co-insurance apply. **Outpatient Surgery:** No co-pay. Deductible and co-insurance apply.
Prescription Drugs (Some Injectible Drugs may be Covered under Outpatient Services)	**Retail: (for a 30-day supply)** Generic: $20 Brand name preferred: $40 Brand name non-preferred: $60	**Retail: (for a 30-day supply)** Generic: $25 Brand name preferred: $45 Brand name non-preferred: $65
Prescription Mail Order	2x prescription cost share per 90 day supply.	Not covered.
Acupuncture	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan. No co-pay. Deductible and co-insurance apply.	No co-pay. Deductible and co-insurance apply.
Ambulance Services	Plan pays 80%, you pay 20%.	Same as in-network.
Chemical Dependency	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.
Devices, Equipment and Supplies Durable medical equipment, Orthopedic appliances, Post-mastectomy bras limited to two (2) every six (6) months, Ostomy supplies, Prosthetic devices	Covered at 80%.	Covered at 80%, deductible applies.
Diabetic Supplies	Insulin, needles, syringes and lancets–see Prescription drugs. External insulin pumps, blood glucose monitors and supplies–see Devices, Equipment and Supplies. Diabetic test strips related to glucose monitor are covered in full. Blood glucose monitoring reagents and urine testing reagents are covered in full.	Insulin, needles, syringes and lancets–see Prescription drugs. External insulin pumps, blood glucose monitors and supplies–see Devices, Equipment and Supplies. Diabetic test strips related to glucose monitor are covered in full. Blood glucose monitoring reagents and urine testing reagents are covered in full.
Diagnostic Lab and X-ray Services	**Inpatient:** Covered under Hospital Services. **Outpatient:** Deductible and co-insurance apply. High-end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital Services. **Outpatient:** Deductible and co-insurance apply. High-end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.
Emergency Services (Co-pay Waived if Admitted)	$125 co-pay. Deductible and co-insurance apply.	$125 co-pay. Deductible and co-insurance apply.

HEWT GroupHealth Options Medical Plan (cont'd)

EFFECTIVE 1/1/2014

Benefits	Inside Network	Out-of-Network
Hearing Exams (Routine)	No co-pay. Deductible and co-insurance apply.	No co-pay. Deductible and co-insurance apply.
Hearing Hardware	$400 per ear every 36 months.	Benefit shared with in-network.
Home Health Services	Covered in full. No visit limit.	No visit limit. Deductible and co-insurance apply.
Hospice Services	Covered in full.	Deductible and co-insurance apply.
Infertility Services	50% diagnostic services & drugs, deductible and co-insurance apply.	Shared with in-network.
Manipulative Therapy	Self-referred up to 20 visits per calendar year. No co-pay. Deductible and co-insurance apply.	Visit limits shared with in-network. No co-pay. Deductible and co-insurance apply.
Massage Services	See Rehabilitation services.	See Rehabilitation services.
Maternity Services	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.
Mental Health	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.
Naturopathy Services	Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan. No co-pay. Deductible and co-insurance apply.	No co-pay. Deductible and co-insurance apply.
Obesity-Related Surgery (Bariatric)	Covered at cost shares when medical criteria is met.	Not covered.
Organ Transplants Donor Search & Harvest	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.
Preventive Care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full.	No co-pay, deductible and co-insurance apply.
Rehabilitation Services (Occupational, Speech and Physical Including Services for Neurodevelopmentally Disabled Children Age Six and Under). Rehabilitation Visits are a Total of Combined Therapy Visits Per Calendar Year.	**Inpatient:** 60 days per condition PCY, deductible and co-insurance apply. **Outpatient:** 60 visits per condition PCY. No co-pay. Deductible and co-insurance apply.	**Inpatient:** Day limits shared with in-network. Deductible and co-insurance apply. **Outpatient:** Visit limits shared with in-network. No co-pay. Deductible and co-insurance apply.
Skilled Nursing Facility	Up to 60 days per calendar year, deductible and co-insurance apply.	Day limits shared with in-network benefit, deductible and co-insurance apply.
Sterilization (Vasectomy, Tubal Ligation)	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.
Temporomandibular Joint (TMJ) Services	$1,000 per calendar year; $5,000 lifetime max. **Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	Shared with in-network. **Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.
Tobacco Cessation See Pharmacy Benefit for Associated Drug Coverage	Free & Clear Program–covered in full.	Not covered.
Routine Vision Care (1 Visit Every 12 Months)	No co-pay. Deductible and co-insurance waived.	Covered up to $50 UCR once every 12 consecutive months.
Optical Hardware Lenses, including contact lenses and frames	$165 per 24 months. Not subject to deductible and co-insurance.	Benefit limits shared with in-network.