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Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible [1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
Individual	$0	
Family	$0	

Out of Pocket Information

Out of Pocket Maximum [1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
Individual	$5,000	
Family	$10,000	

Schedule of Benefits

The following table represents the medical services currently covered under the IHP Premier Plan, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

Plan Provisions	Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
		Member Pays	
PHYSICIAN SERVICES			
Primary Care OfficeVisit (Limited to 12 visits per plan year)	No	$15 Copay	$15 Copay
Specialist Office Visit (Includes Mental and Behavioral Health. Limited to 12 visits per plan year)	No	$25 Copay	$25 Copay
Other Physicians Services performed in the office[4] (Limited to Primary Care/Specialists visits per plan year)	Yes[5]	$50 Copay per service billed	$50 Copay per service billed
Urgent Care (Limited to 3 visits per plan year)	No	$35 Copay	$35 Copay
Telemedicine Services	No	$0 Copay	Not Applicable

[1] The Deductible and Out of Pocket amounts are combined across In Network and Out of Network Providers.

[2] In addition to the copay listed, the member will also be responsible for any billed charges in excess of 102% of the Medicare reimbursement rate.

[3] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.

[4] The plan will only reimburse buy and bill drugs up to the lessor of the allowed amount or network rate or the amount that the Third-Party Administrator or Pharmacy Benefits Manager could source the drug for.

[5] Prior authorization is required for any service or procedure over $1,000.

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Plan Provisions		Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
			Member Pays	
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services section)	**(Non-Hospital Based)**	No	$0 Copay	$0 Copay
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
HOSPITAL/FACILITY SERVICES (Subject to RBP)				
Inpatient Hospitalization (Limited to 10 days per plan year)		Yes	$350 Copay per admission (After copay, benefit subject to RBP)	
Inpatient Visits - Physician (Limited to visits up to 10 days per plan year)		No	Included in Inpatient Hospitalization Copay	
Inpatient Surgery - Physician Charges (Limited to 4 surgeries per plan year)		Yes	Included in Inpatient Hospitalization Copay	
Outpatient Hospital or Free-Standing Facility Services and Surgery (Limited to 2 visits per plan year)		Yes	$350 Copay (After copay, benefit subject to RBP)	
Anesthesia (Limited to 4 inpatient and 2 outpatient anesthetic procedures per plan year)		No	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay	
Emergency Room Services (Limited to 2 visits per plan year)		No	$350 Copay (After copay, benefit subject to RBP)	
OUTPATIENT DIAGNOSTIC SERVICES				
Laboratory Service	**(Non-Hospital Based)** (Combined limit of 4 visits per plan year with Radiology)	No	$50 Copay	$50 Copay
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Radiology	**(Non-Hospital Based)** (Combined limit of 4 visits per plan year with Laboratory Services)	No	$50 Copay	$50 Copay
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
CT/MRI/MRA/PET Scan (Limited to 3 per plan year)	**(Non-Hospital Based)**	Yes	$350 Copay (After copay, benefit subject to RBP)	
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member

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Plan Provisions		Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
			Member Pays	
PREGNANCY BENEFITS				
Professional Services		No	$350 Copay	$350 Copay
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)		Yes	$350 Copay per admission (After copay, benefit subject to RBP)	
OTHER SERVICES				
Allergy Services (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)		No	$25 Copay	$25 Copay
Chiropractic Services (Limited to 10 visits per plan year)		No	$25 Copay	$25 Copay
Second Surgical Opinion		No	$0 Copay	Not Covered 100% paid by Member
Home Health Care (Limited to 20 visits per plan year)		Yes	$25 Copay	Not Covered 100% paid by Member
Treatment for Chemical Abuse & Dependency	**(In-Patient or Partial Day)** (Limited to 10 days per plan year)	Yes	$250 Copay per day (After copay, benefit subject to RBP)	
Treatment for Chemical Abuse & Dependency	**(Out-Patient)** (Limited to 12 visits per plan year)	Yes	$25 Copay	$25 Copay
Rehabilitation/Habilitation Services (Combined limit of 12 visits per plan year with physical, speech, and occupational therapies. Prior authorization is required after 6 visits.)		Yes	$50 Copay	Not Covered 100% paid by Member
Emergency Medical Transportation (By land only; Limited to 2 transports per plan year)		No	$250 Copay (After copay, benefit subject to RBP)	

PHARMACY BENEFITS		Participating Pharmacies	Non-Participating Pharmacies
		Member Pays	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic - $0 Copay (Limited to Preventive Generic)	Not Covered 100% paid by Member
Non-Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic - $5 Copay Preferred Brand - $40 Copay Non-Preferred Brand - $80 Copay	Not Covered 100% paid by Member
Pharmacy Mail Order – 90-day supply		Generic - $15 Copay Preferred Brand - $120 Copay Non-Preferred Brand - $240 Copay	Not Covered 100% paid by Member
Non-Limited Brand, & Specialty Drugs		Not Covered 100% paid by Member	Not Covered 100% paid by Member

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Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
   a. Sports,
   b. Camp,
   c. Employment,
   d. Travel
   e. Insurance,
   f. Marriage,
   g. Legal proceedings
2. Routine foot care for treatment of the following:
   a. Flat feet,
   b. Corns,
   c. Bunions,
   d. Calluses,
   e. Toenails,
   f. Fallen arches,
   g. Weak feet,
   h. Chronic foot strain
3. Dental procedures
4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by any appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Claims which would otherwise be covered by a Worker's Compensation policy for which a participant is entitled to benefit
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to an act of war, declared or undeclared, not including acts of terrorism
14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
15. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational
21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
25. Any claims for fertility or infertility treatment
26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits

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Exclusions

24. Claims for disability resulting from reversal of sterilization
25. Claims for the completion of forms, or failure to keep scheduled appointments
26. Recreational or diversional therapy
27. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
28. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
29. Claims that arise primarily due to medical tourism
30. Supportive devices of the foot
31. Treatments for sexual dysfunction
32. Aquatic or massage therapy
33. Biofeedback training
34. Skilled nursing facilities
35. Durable medical equipment and prosthetics
36. Hospice care, private duty nursing, or long-term care
37. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
38. Claims for temporomandibular joint syndrome
39. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs
40. Genetic testing unless explicitly covered in the schedule of benefits
41. Human Cell, Tissue and Organ transplantation
42. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.
43. Radiation and chemotherapy
44. Dialysis
45. Acupuncture
46. Alternative medicine/homeopathy
47. Children dental and vision
48. Neonatal intensive care (NICU)
49. Routine eye care (Adult)
50. Inpatient facility claims for surgery after the inpatient hospital day limit per plan year has been exhausted
51. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands
52. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded.
53. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).
54. Diagnosis and treatment for sleep apnea
55. Gene therapy
56. Use of Emergency Room Services for non-emergency care
57. Private room unless medically necessary or if a semi-private room is not available
58. Emerging gene and cell therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.