

Your Summary of Benefits



Educational Purchasing Council - Madison-Plains Lumenos Health Reimbursement Accounts (with Copay) Effective October 1, 2015

Covered Benefits	Network	Non-Network
Employer Health Reimbursement Account Contribution: Single: \$4,750 Family: \$9,500		
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: \$5,000 Family: \$10,000	Single: \$5,750 Family: \$11,500
Employee Bridge Amount*	Single: \$250 Family: \$500	
Out-of-Pocket Limit	Single: \$6,000 Family: \$12,000	Single: \$7,750 Family: \$13,500
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> Allergy injections (PCP and SCP) Allergy testing MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals 	\$20/\$20 No Cost Share No Cost Share No Cost Share	30% 30% 30% 30%
Preventive Care Services <ul style="list-style-type: none"> Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening 	No Cost Share	30%
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room Services @Hospital (facility/other covered services) (copayment waived if admitted) Urgent Care Center Services 	\$150 \$75	\$150 30%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical Care visits, Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 	0%	30%
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Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 180 days for skilled nursing facility 	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	0%	30%
Other Outpatient Services including but not limited to: <ul style="list-style-type: none"> Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. Home Care Services 200 visits (excludes IV Therapy) Network/Non-network combined) Durable Medical Equipment, Orthotics and Prosthetics Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	No Cost Share 0% No Cost Share No Cost Share No Cost Share No Cost Share	30% 30% 30% 30% No Cost Share No Cost Share
Accidental Dental Services \$3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	30%
Outpatient Therapy Services: (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Cardio Rehabilitation: No visit limit Pulmonary Rehabilitation: No visit limit Physical therapy: 20 visits Occupational therapy: 20 visits Speech therapy: 50 visits Manipulation therapy: 20 visits 	\$20/\$20 \$20	30% 30%
Behavioral Health Services: Mental Illness and Substance Abuse¹ <ul style="list-style-type: none"> Inpatient Facility Services Physician Home and Office Visits Other Outpatient Services @ Hospital/Alternative Care Facility 	Benefits provided in accordance with Federal Mental Health Parity	30% 30% 30%

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Human Organ and Tissue Transplants <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	No Cost Share	50%
Prescription Drugs: Administered by CVS/Caremark	See Your Prescription Benefit Plan Summary	See Your Prescription Benefit Plan Summary

Notes:

- All medical deductibles, copayments and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). Once the Medical OOP max is met, no additional cost share applies.
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%. Once the deductible is met, the appropriate coinsurance applies.
- Copayments are not subject to the medical deductible.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance and copayments will be required before the family out-of-pocket is satisfied.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- **Dependent Age:** to end of the month which the child attains age 26.
- 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit period = calendar year
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- No H R A contribution amount may be rolled over to the next year.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Private Duty Nursing – limited to 82 visits/Calendar Year.
- Wigs limited to 1 per benefit period
- Vision limited services - additional vision services are covered when specifically coded as determination of refraction, routine ophthalmological examination including refraction for new and established patients, and a visual functional screening for visual acuity. No additional ophthalmological services are covered as part of the medical coverage.

1 We encourage you to review the Schedule of Benefits for limitations.

*Bridge is not an insurance term and does not appear in the Certificate. HRA funds can be used for covered medical services under the benefit plan. Bridge amounts may be reduced if Incentives are earned and by Contribution Rollover amounts in subsequent years. Employer must fund in order to be considered a Health Reimbursement Account. Employer must continue to fund for the entire year at the HRA level indicated.

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Precertification:

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: None .

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

This benefit overview is for illustrative purposes and some content may be pending Ohio Department of Insurance approval

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Your Prescription Benefit Plan Copay Overview

Madison-Plains HRA 10/01/2015

Your plan is based on a maximum “out of pocket” design which integrates both medical and pharmacy benefits. Your maximum out of pocket is \$600 for an individual or \$1,200 for a family.

	CVS/caremark Retail Pharmacy Network For short-term medications (Up to a 30-day supply)	CVS Caremark Mail Service Pharmacy For long-term medications (Up to a 90-day supply)
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	\$10 for a generic prescription	\$20 for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan’s preferred drug list.	\$30 for a preferred brand-name prescription	\$60 for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan’s preferred drug list.	\$50 for a non-preferred brand-name prescription	\$100 for a non-preferred brand-name prescription
Refill Limit	None	None
Maximum Out-of-Pocket	\$600 per individual / \$1,200 per family	
Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates “dispense as written,” you will pay the difference between the brand-name medication and the generic plus the brand copayment.		

Where to fill your prescription

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS/caremark retail network.

- Choose from more than 68,000 network pharmacies nationwide, including independent pharmacies, chain pharmacies and 7,700 CVS/pharmacy locations.
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription, and use a pharmacy in the CVS/caremark retail network.

Long-term medications are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions.

Choose **one** of three easy ways to start using the CVS Caremark Mail Service Pharmacy:

1. Fill out and send in a mail service order form – use the one included in this welcome kit or print one at www.caremark.com
2. Visit www.caremark.com/faststart
3. Call FastStart toll-free at 1-800-875-0867

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week. You can either e-mail customerservice@caremark.com or call toll-free at 1-888-202-1654 after your benefits begin. For TDD assistance, please call toll-free 1-800-863-5488.

Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.