

Tuality Healthcare

Medical/Prescription Drug Benefit Plans Effective January 1, 2007

	PLAN 1 — SELECT PLAN	PLAN 2 — CHOICE PLAN PPO	
	(Tuality Healthcare Alliance)	(MHN ^(a) Providers)	(Any Provider)
	THA In-Network	In-Network	Out-of-Network
Plan Provisions and Services			
Plan Provisions			
Calendar Year Deductible^(b)			
Individual	\$300		\$350
Family	\$600		\$1,050
Medical Out-of-Pocket Maximum (includes deductible and non-Rx copays, if applicable) ^(c)			
Individual	\$2,300 ^(d)	\$2,350 minimum to \$4,350 maximum depending on percentage paid toward covered services ^(d)	
Family	\$4,600 ^(d)	\$4,700 minimum to \$8,700 maximum depending on percentage paid toward covered services ^(d)	
Maximum Benefit — Lifetime (Per Person)	\$2,000,000		\$2,000,000
Chiropractic Maximum Benefit — Calendar Year (Per Person)	\$1,000		Not covered
Pre-Existing Condition Limitations	No limitations		No limitations
Physician's and Other Outpatient Services	All benefits subject to deductible except as noted. Below provisions are based on "eligible expenses."	All benefits subject to deductible except as noted. Below provisions are based on "eligible expenses."	
Physician Services^(e)			
Routine care	\$15 copay per office visit (deductible waived)	20% coinsurance	40% coinsurance
Diagnosis and treatment of illness or injury			
Maternity office care and delivery (Employee and Spouse) ^(f)	\$50 copay per pregnancy	20% coinsurance (deductible waived)	
Specialist Visit^(e)			
Specialty care	\$25 copay per office visit (deductible waived)	20% coinsurance	40% coinsurance
Diagnosis and treatment of illness or injury			
Preventive Care^(e)			
Well-child care ^(g)			
Immunizations ^(g)			
Periodic checkups ^(g)			
Colonoscopy ^(h)	\$15 copay per office visit (deductible is waived; no copayment on well-child care visits during the first two years)	20% coinsurance (deductible waived)	40% coinsurance
Mammography ⁽ⁱ⁾			
Well-woman care ⁽ⁱ⁾			
Prostate screening			

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Hearing Exams (Children through age 17) Annual screening exams	\$15 copay per office visit (deductible waived)	20% coinsurance (deductible waived)	40% coinsurance
Injections, Including Allergies (medically necessary) ⁽ⁱ⁾	\$15 copay per visit; no copay for allergy injections (deductible waived)	20% coinsurance	40% coinsurance
Emergency Room Care ^(e) Copay is waived if admitted directly from the emergency room to the hospital. Medical emergency ^(k)	\$75 copay per visit (deductible waived) (In-Plan and out-of-service area true emergencies)	\$100 copay per visit (deductible waived)	40% coinsurance after \$100 copay per visit (deductible waived)
Non-emergency care	20% coinsurance after \$75 copay per visit (deductible waived)	20% coinsurance after \$100 copay per visit (deductible waived)	40% coinsurance after \$100 copay per visit (deductible waived)
Urgent Care Center ^(e) Services for immediate care when your physician is not available, or after normal office hours.	In-Plan: \$25 copay per visit (deductible waived) Out-of-Service-Area Emergencies: \$50 copay per visit (deductible waived)	20% coinsurance	40% coinsurance
Outpatient Surgery ^(l) Use of operating room in hospital or authorized outpatient center (including birthing centers)	20% coinsurance (pre-certification is not required on surgeries performed in the physician's office)	20% coinsurance (pre-certification is not required on surgeries performed in the physician's office)	40% coinsurance (pre-certification is not required on surgeries performed in the physician's office)
Outpatient Rehabilitation Limit of 30 visits per calendar year (60 visits per calendar year for head and spinal cord injuries or for treatment of stroke)			
Short-term physical therapy ^(m)	20% coinsurance	20% coinsurance	40% coinsurance
Short-term occupational therapy	20% coinsurance	20% coinsurance	40% coinsurance
Short-term speech therapy	20% coinsurance	20% coinsurance	40% coinsurance
Chiropractic Services Services must be provided by Complementary Healthcare Plans, Inc. providers	20% coinsurance	Not covered	Not covered
Biofeedback Therapy Limit of 30 visits per calendar year (60 visits per calendar year for head and spinal cord injuries or for treatment of stroke)	20% coinsurance	20% coinsurance	40% coinsurance
Outpatient Diabetic Instruction Services Health care professionals instruction services	100% (no copay and deductible waived)	100% (deductible waived)	100% (deductible waived)
Lab and X-ray Services X-rays Lab tests	20% coinsurance	20% coinsurance	40% coinsurance

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Hospital Services			
Hospital Care ^(l)			
Room and board — semi-private	20% coinsurance	20% coinsurance	40% coinsurance
Maternity and routine nursery	20% coinsurance	20% coinsurance	40% coinsurance
Intensive care	20% coinsurance	20% coinsurance	40% coinsurance
Cardiac care	20% coinsurance	20% coinsurance	40% coinsurance
Physician hospital visits	20% coinsurance	20% coinsurance	40% coinsurance
Surgical services ^(l)	20% coinsurance	20% coinsurance	40% coinsurance
Anesthesiology fees ^(l)	20% coinsurance	20% coinsurance	40% coinsurance
Rehabilitative Therapy ^(m)			
Limit of 30 visits per calendar year (60 visits per calendar year for head and spinal cord injuries or for treatment of stroke)	20% coinsurance	20% coinsurance	40% coinsurance
Lab Tests	20% coinsurance	20% coinsurance	40% coinsurance
Other Covered Services			
Mental Health/ Chemical Dependency ⁽ⁿ⁾	(Select plan allows MHN Mental Health/ Chemical Dependency providers)		
Inpatient ^(l)	20% coinsurance	20% coinsurance	40% coinsurance
Outpatient	20% coinsurance	20% coinsurance	40% coinsurance
Residential ^(l)	20% coinsurance	20% coinsurance	40% coinsurance
(Services subject to duration limits and maximum benefit levels)			
Home Health Care ^(l)			
Limit 60 visits per calendar year	\$15 copay per visit (deductible waived)	20% coinsurance	40% coinsurance
Bereavement Counseling	20% coinsurance	20% coinsurance	40% coinsurance
Skilled Nursing Facility ^(l)			
Up to 100 days per calendar year	20% coinsurance	20% coinsurance	40% coinsurance
Hospice Care ^(l)	No copay and deductible waived; limited to six months	20% coinsurance; limited to six months	40% coinsurance; limited to six months
Organ Transplants ^(l)	20% coinsurance	20% coinsurance	40% coinsurance
Ambulance	\$100 copay per incident (deductible waived)	20% coinsurance	40% coinsurance
Anesthesiology Services ^(l)			
Outpatient fees	20% coinsurance	20% coinsurance	40% coinsurance
Dialysis Services			
Professional services and center	20% coinsurance	20% coinsurance	40% coinsurance
Chemotherapy ^(o)			
Professional and facility services	20% coinsurance	20% coinsurance	40% coinsurance
TMJ Services ^(l)			
(Mandatory second surgical opinion required)	50% coinsurance; benefit limited to \$1,000 per calendar year and \$5,000 lifetime	50% coinsurance; benefit limited to \$1,000 per calendar year and \$5,000 lifetime	50% coinsurance; benefit limited to \$1,000 per calendar year and \$5,000 lifetime
Non-Dental Oral Surgery	20% coinsurance	20% coinsurance	40% coinsurance
Durable Medical Equipment, Prosthetic Devices, and Supplies ^(l)	20% coinsurance	20% coinsurance	40% coinsurance

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Family Planning Services Vasectomy Tubal ligation Infertility Voluntary interruption of pregnancy Orthotics (\$200 calendar year maximum)	20% coinsurance 20% coinsurance 50% per procedure to a \$10,000 lifetime maximum benefit 50% per procedure 20% coinsurance	20% coinsurance 20% coinsurance 50% per procedure to a \$10,000 lifetime maximum benefit 50% per procedure 20% coinsurance	40% coinsurance 40% coinsurance 50% per procedure to a \$10,000 lifetime maximum benefit 50% per procedure 40% coinsurance
Prescription Drugs ^(c)			
Managed Pharmacy ^(p) Retail (30-day supply) Mail Order (90-day supply) ^(q) Prescription Drug Annual Out-of-Pocket Maximum (Applies to Retail and Mail Order Drugs) A listing of preferred brand drugs can be obtained from Pharmicare.	Administered by Pharmicare Prescription drug purchases at a participating pharmacy. Generic: \$12 Preferred Brand: 20% (\$20 minimum; \$70 maximum) Non-Preferred Brand: 35% (\$40 minimum; \$90 maximum) Prescription drug purchases ordered through mail order vendor. Generic: \$30 Preferred Brand: \$60 Non-Preferred Brand: \$100 \$2,000 per individual Mandatory Generic Requirement: All prescriptions filled under the retail or mail order prescription drug program will be automatically filled with the generic version of the medication (if one is available). Otherwise, you will be charged the difference in the price between the brand-name and generic version of that medication, <i>plus</i> the generic copay.	Administered by Pharmicare Prescription drug purchases at a participating pharmacy. Generic: \$12 Preferred Brand: 20% (\$20 minimum; \$70 maximum) Non-Preferred Brand: 35% (\$40 minimum; \$90 maximum) Prescription drug purchases ordered through mail order vendor. Generic: \$30 Preferred Brand: \$60 Non-Preferred Brand: \$100 \$2,000 per individual (Combined In-Network and Out-of-Network prescription drugs) Mandatory Generic Requirement: All prescriptions filled under the retail or mail order prescription drug program will be automatically filled with the generic version of the medication (if one is available). Otherwise, you will be charged the difference in the price between the brand-name and generic version of that medication, <i>plus</i> the generic copay.	Administered by Pharmicare If you use a non-participating pharmacy, you will pay 100% of the prescription cost at the time of purchase. You must then file a paper claim form along with the original prescription receipt to Pharmicare for covered medications. The out-of-network pharmacy cost will be paid at the same amounts as an in-network pharmacy. The plan participant pays the difference. Not covered. Must use mail order vendor (see in-network).

Endnotes:

- (a) Managed Healthcare Northwest (MHN).
- (b) Calendar year deductible does not include any copayments.
- (c) Managed Pharmacy (retail and mail order) drug copays do not apply to the medical out-of-pocket maximum. There is a separate \$2,000 out-of-pocket maximum per individual that applies to prescription drugs.
- (d) The out-of-pocket maximum does not include prescription drug copayments and cost containment penalties.
- (e) Depending on how services are billed, there may be additional costs to you if lab and x-ray services are ordered in conjunction with these services. Refer to the Lab and X-ray Services (page 2) for the coinsurance levels. Also, you may be subject to out-of-pocket expenses (copayment, coinsurance, and/or deductible, if applicable) if billed separately by the physician.
- (f) Contact ICM to join the Healthy Mother Baby Program at no cost to you. You will receive a gift certificate from Tuality to join this program.
- (g) Services must be provided by your PCP and in accordance with the following schedule: Well-baby-up to 8 visits during the first 24 months of life; Ages 2-6 – One exam per calendar year; Ages 7-18 – One exam every two calendar years; Ages 19-34 – One exam every four calendar years; Ages 35 and above – One exam every two calendar years. Physical exams are calculated according to age from previous date of service. Immunizations for plan participants over 18, the plan covers only those immunizations recommended by the American Academy of Family Physicians. Immunizations for hepatitis B are covered only for enrolled dependent children under age 19. Covered immunizations do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country. Immunization copay is waived if received in conjunction with a \$15 office visit copay.
- (h) Age 50 and above — one colonoscopy every five years. The plan will not cover colonoscopies more frequently than the allowed schedule unless the patient is designated high risk.
- (i) No referral is required if covered services are received from a PCP or a women's health care provider who is a participating provider. Services for women are in accordance with the following schedule: Ages 35-40: One mammogram during that five-year period; Age 40 and above: One mammogram per calendar year; If designated high risk: As recommended by your PCP or women's health care provider.
- (j) Chemotherapy injections are paid under the chemotherapy benefit (see page 3).
- (k) An emergency medical condition means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.
- (l) Must have prior approval of medical management (above \$500 for DME and supplies or for rental of DME equipment longer than three months). Benefits will be reduced by 25 percent if proper authorization is not obtained. Case management services are provided by Innovative Care Management.
- (m) Participant may "self-refer" to Certificate Athletic Trainer (Sports Medicine Specialists) for treatment of sports related injuries (no physician referral required) accessed only through Tuality Healthplace.
- (n) Maximum duration for treatment settings for mental health and chemical dependency during a 24-consecutive month period (beginning with the first use of service) are as follows:
 - (i) Mental Health (Adults and Children): Inpatient care-11 days; Residential/partial hospitalization/day care-19 days; Outpatient care-26 visits.
 - (ii) Chemical Dependency: Inpatient-Adult: 12 days; Children: 16 days. Residential/partial hospitalization/day care-Adult: 19 days; Children-24 days. Outpatient-Adults: 20 visits; Children: 26 visits.

- (o) Injections received in the physician's office are paid under the chemotherapy benefit provision (not as a physician office visit).
- (p) Some prescription drug medications require preauthorization or they may have internal plan limits. Please contact Pharmacare regarding any limits or restrictions to the prescription drug program.
- (q) By law, Pharmacare must fill your prescription for the exact quantity of medication prescribed by your health care provider, up to the 90-day plan limit. "30 days plus 2 refills" does not equal one prescription written for "90 days." Be sure your health care provider writes the prescription accurately. All services are subject to UCR (usual, customary, and reasonable charges).
- (r) Only medically necessary services are covered (except for listed Preventive Care Services).
- (s) Additional In-Plan Only Provisions (Select Plan 1 and Choice PPO Plan 2):
 - (i) Covered services provided by a non-participating radiologist, anesthesiologist or pathologist while hospital confined in an In-Plan hospital will be payable at the In-Plan benefit level of benefits.
 - (ii) Non-participating emergency room hospital services rendered for a medical emergency will be payable at the In-Plan provider level of benefits if choice of hospital was beyond the control of the covered person.
 - (iii) Services required while out of the service area (service area is within 25 miles or more from residence): The plan participant should call Innovative Care Management (ICM) for prior authorization if treatment is not a life-threatening emergency.
- (t) Additional In-Plan Provisions (Select Plan 1 Only):
 - (i) Charges for services rendered by a provider whose specialty is not available in the network area will be considered at the In-Plan provider level of benefits, subject to the deductible, copayments and coinsurance (if applicable), out-of-pocket maximum amount, and benefit limitations.
 - (ii) Coverage for dependents (eligible spouse/children) out of the network service area (service area is within 25 miles or more from residence): \$300 per person calendar year deductible; 20 percent coinsurance; \$2,300 individual maximum out-of-pocket maximum.

This benefit summary is intended to provide highlights of your medical and prescription drug options. If there is a discrepancy between this summary and the official plan document, the plan document will govern plan provisions and how benefits are paid.