National Health Care, Inc and Affiliates
Voluntary Employee Benefit Association Plan
Bronze Plan
Medical and Prescription Drug Benefit Schedule
Effective January 1, 2021

NOTE: "The information provided is neither an offer of coverage nor medical advice. It is only a partial, general description of plan or program benefits and does not constitute a contract. In case of a conflict between your plan documents and this information, the plan documents will govern."

Deductible and Out-of-Pocket Maximum	
Calendar Year Deductible	$6,600 Individual $13,200 Family
Out-of-Pocket Maximum* (Includes Deductible)	$6,600 per person $13,200 per family
*When the Out-of-Pocket Maximum is reached, Plan payments will increase to 100%. The following expenses do not apply toward your Out-of-Pocket Maximum: non-covered expenses and charges that exceed Usual, Customary and Reasonable charges.	

Provisions and Limitations
Utilization Review Services
Hospital Pre-admission Certification; Concurrent Review; Discharge Planning and Maternity Care Review. Other services may require pre-certification. Please review plan document for details.
Hospital Pre-admission Certification
Certification is required for : Hospital Admissions; Treatment Facility Admissions; Convalescent Facility Admissions; Home Health Care; Hospice Care; Private Duty Nursing.

Covered Medical Expenses	
Service	**Plan Pays**
Hospital Expenses	
Inpatient Room & Board & Ancillary	100% after deductible
Inpatient Maternity Care (Includes delivery and postpartum care)	100% after deductible
Outpatient Facility (medical)	100% after deductible
Outpatient Facility (surgical)	100% after deductible
Outpatient Facility (DXL)	100% after deductible
Advanced Imaging, CT, MRI, Pet Scans (Hospital Based)	100% after deductible
Physicians' and Surgical Expenses	
Inpatient Surgery**	100% after deductible
Inpatient Visits	100% after deductible
Outpatient Surgery (Hosp/ASC)	100% after deductible
Outpatient Surgery (office)**	100% after deductible
Second and Third Surgical Opinions	100% after deductible
Pre Natal Maternity Visits	100%
Specialist Office Visits (Includes diagnostic services)	100% after deductible
Office Visits – Primary Care Physician Internist, General, Family Practitioner or Pediatrician (Includes diagnostic services)	100% after deductible

****Anesthesia is paid at the same level as Surgery**

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Covered Medical Expenses	
Service	**Plan Pays**
Mental Health Treatment Expenses	
Inpatient Hospital	100% after deductible
Inpatient Physician Visits	100% after deductible
Outpatient Visits	100% after deductible
Substance Abuse Treatment Expenses	
Inpatient Rehab	100% after deductible
Inpatient Detox	100% after deductible
Inpatient Physician Visits	100% after deductible
Outpatient Rehab Visits	100% after deductible
Outpatient Detox Visits	100% after deductible
Emergency Care***	
Emergency Room (Hospital)	100% after deductible
Emergency Room Physician	100% after deductible
Emergency Room Diagnostic	100% after deductible
Non-Emergent use of ER	Not Covered
Urgent Care Facility	100% after deductible
Retail Clinic	100% after deductible
Preventive Care Expenses*	
Immunization	100%
Routine Annual Physical Exam	100%
Routine Colorectal Screening	100%
Routine Diagnostic Procedures	100%
Routine Eye Exams	100%
Routine Gynecological Procedure	100%
Routine & Digital 3D Mammography	100%
Well-Child Care	100%
Routine Hearing Screening	100%
Therapies	
Cardiac Rehab	100% after deductible
Chemotherapy/Radiation Therapy	100% after deductible
Dialysis	100% after deductible
Occupational Therapy	100% after deductible
Physical Therapy	100% after deductible
Respiratory Therapy	100% after deductible
Speech Therapy (Restorative purposes only)	100% after deductible

* **Preventive Care are covered pursuant to PPACA/Health Care Reform guidelines**

*****Emergency room Copayments will also be waived if the Member was directed by the treating physician at the Urgent Care Center to go immediately to an emergency room as the more appropriate medical setting for the required treatment.**

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Covered Medical Expenses	
Service	
Other Covered Expenses	
Ambulance Service	100% after deductible
Allergy Injections	100% after deductible
Allergy Testing	100% after deductible
Allergy Serum	100% after deductible
Autism Behavioral Therapy	Same as Mental Health Coverage
Autism Therapies (PT/OT/ Speech)	100% after deductible
Bariatric / Gastric Bypass Surgery	Not Covered
Chiropractic/Spinal Manipulation	100% after deductible
Contraceptive Management	100%
Advanced Imaging, CT, MRI, Pet Scans (Freestanding Facility)	100% after deductible
Advanced Imaging, CT, MRI, Pet Scans (Hospital Based)	100% after deductible
Diagnostic, X-ray and Lab (Freestanding Facility)	100% after deductible
Diagnostic, X-ray and Lab (Hospital Based)	100% after deductible
Durable Medical Equipment	100% after deductible
Hearing Aids (under the age of 13)	100% after deductible
Home Health Care	100% after deductible
Hospice Care - Inpatient	100% after deductible
Hospice Care – Outpatient	100% after deductible
Nutritional Counseling	Co-insurance based on type of service and where it is performed
Pre-Admission Testing	100% after deductible
Private Duty Nursing - Outpatient	100% after deductible
Orthotics	100% after deductible
Prosthetics	100% after deductible
Routine Hearing Exams	100%
Skilled Nursing & Rehabilitative Facilities	100% after deductible
Sleep Studies	100% after deductible
Telemedicine – MeMD	$40 copay
Tubal Ligation	100%
Vision Exam (every 24 months)	100%
All Other Eligible Medical Expenses	100% after deductible

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Covered Medical Expenses	
Service	
Infertility	
Infertility Diagnostic	Co-insurance based on type of service and where it is performed
Infertility Services	Not Covered
***Prescription Drugs* - Some prescriptions may require preauthorization**	
Prescription	**Coinsurance/Copay**
Non Maintenance Medication: Retail Pharmacy Generic (Up to 30 days)	100% after deductible
Non Maintenance Medication: Retail Pharmacy Brand (Up to 30 days)	100% after deductible
Maintenance Medication: Retail Pharmacy Generic (30/90 days)	100% after deductible
Maintenance Medication: Retail Pharmacy Brand (30/90 days)	100% after deductible
Maintenance Medication: Mail Order Generic (Up to 90 days)	100% after deductible
Maintenance Medication: Mail Order Brand (Up to 90 days)	100% after deductible
Specialty Medication* (Up to 30 days)	100% after deductible

***Must be order from Accredo**

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All benefits described in the Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; and that services, supplies and care are not Experimental and/or Investigational.

Referrals by PPO Physician to a Non-PPO Physician will be considered as Non-PPO Service. In order to receive PPO benefits, ask your Physician to refer you to listed PPO Physician (e.g. specialists, etc.).

However, if you utilize a PPO Provider for treatment and subsequently require services from a Physician under agreement with that provider is not associated with the PPO (e.g., Physicians, anesthesiologists, radiologists, pathologists, etc.) the charges will be considered at the In-Network benefit outlined on the Schedule of Medical Benefits and treated as a PPO Physician not subject to Out-of-Network provision.

All other limitations, requirements and provisions of this Plan will apply. This exception does not apply in the event of consultations and situations in which you and/or your Physician selected or had the opportunity to select a PPO Physician and exercised the right to receive services from a Non-PPO Physician. The Member must provide the proof that a provider does not exist within the 30-mile radius.

A Preferred Provider Organization (PPO) is a negotiated arrangement in which selected Health Care Provider (physicians and ancillary) contract to provide services for you and your eligible Dependents for a pre-determined price. Examples of PPO Professional Providers are Primary Care Providers, Specialist, Chiropractor and OB/GYN. The PPO Network also includes Ancillary Services. The PPO arrangement is beneficial to you, your provider and the Plan. You receive a more cost effective benefit, the Plan saves money because services are performed at lower costs, and the provider gains new patients. Additional information about the PPO option, as well as a list of in-network doctors and facility can be found on the MultiPlan website: https://www.multiplan.com/mpipracanc

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Service	Calendar Year Maximum Benefit per Person
Medical	
Lifetime Maximum for all Eligible Medical Expenses	Unlimited
Autism Applied Behavior Analysis (ABA)	Same as any other Mental Health service benefit
Chiropractic / Spinal Manipulation Services	Up to 20 visits per calendar year
Hearing Aids	Limited to $1,000 max per 24 months for a child to age 13
Hearing Exams	One every 24 months
Home Health Care Services	Up to 80 visits per calendar year
Infertility Diagnosis/Treatment	Limited to diagnosis and treatment of underlying medical condition only
Nutritional Counseling	Limited to 3 visits per calendar year
Outpatient Therapy Physical , Occupational & Speech	Limited to 30 visits per calendar year per therapy
Private Duty Nursing	Limited to 70 eight hour shifts per calendar year.
Skilled Nursing and Rehabilitation Facilities	Up to 60 days per calendar year
Routine Vision Exam	One exam every 24 months and refraction per calendar year by an Optometrist or Ophthalmologist
Prescription Drugs	
Maximum Supply Retail Pharmacy Prescriptions	90 days
Maximum Supply Mail Order Pharmacy Prescriptions	90 days