

**National Health Care, Inc and Affiliates
Voluntary Employee Benefit Association Plan
Premium 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	\$750 Individual \$2,000 Family
Out-of-Pocket Maximum* (Includes Deductible)	\$7,900 per person \$15,800 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	
<i>Utilization Review Services</i>	
Hospital Pre-admission Certification; Concurrent Review; Discharge Planning and Maternity Care Review. Other services may require pre-certification. Please review plan document for details.	
<i>Hospital Pre-admission Certification</i>	
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
<i>Hospital Expenses</i>	
Inpatient Room & Board & Ancillary	\$500 copay after deductible
Inpatient Maternity Care	\$500 copay after deductible
Outpatient Facility (medical)	\$500 copay after deductible
Outpatient Facility (surgical)	\$500 copay after deductible
Outpatient Facility (DXL)	100% after \$25 copay
Advanced Imaging, CT, MRI, Pet Scans (Hospital Based)	100% after \$500 copay
<i>Physicians' and Surgical Expenses</i>	
Inpatient Surgery**	100% after deductible
Inpatient Visits	100% after deductible
Outpatient Surgery (Hosp/ASC)	100% after deductible
Outpatient Surgery (office)**	100% after \$40 copay
Second and Third Surgical Opinions	100% after deductible
Pre Natal Maternity Visits	100%
Specialist Office Visits (Includes diagnostic and lab services)	100% after \$40 copay
Office Visits – Primary Care Physician Internist, General, Family Practitioner or Pediatrician (Includes diagnostic and lab services)	100% after \$30 copay

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

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Covered Medical Expenses	
Service	Plan Pays
<i>Mental Health Treatment Expenses</i>	
Inpatient Hospital	\$500 copay after deductible
Inpatient Physician Visits	100% after deductible
Outpatient Visits	\$40 copay
<i>Substance Abuse Treatment Expenses</i>	
Inpatient Rehab	\$500 copay after deductible
Inpatient Detox	\$500 copay after deductible
Inpatient Physician Visits	100% after deductible
Outpatient Rehab Visits	\$40 copay
Outpatient Detox Visits	\$40 copay
<i>Emergency Care***</i>	
Emergency Room (Hospital)	\$250 copay (copay waived if admitted)
Emergency Room Physician	100%
Emergency Room Diagnostic	100%
Non-Emergent use of ER	Not Covered
Urgent Care Facility	\$50 copay
Retail Clinic	\$30 copay
<i>Preventive Care Expenses*</i>	
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%
<i>Therapies</i>	
Cardiac Rehab	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Chemotherapy/Radiation Therapy	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Dialysis	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Occupational Therapy	\$45 copay
Physical Therapy	\$45 copay
Respiratory Therapy	\$45 copay
Speech Therapy (Restorative purposes only)	\$45 copay

* 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	
<i>Other Covered Expenses</i>	
Ambulance Service	100%
Allergy Injections	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Allergy Testing	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Allergy Serum	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Autism Behavioral Therapy	Same as Mental Health Coverage
Autism Therapies (PT/OT/ Speech)	\$45 copay
Bariatric / Gastric Bypass Surgery	Not Covered
Chiropractic/Spinal Manipulation	\$45 copay
Contraceptive Management	100%
Advanced Imaging, CT, MRI, Pet Scans (Freestanding Facility)	100% after \$250 copay
Advanced Imaging, CT, MRI, Pet Scans (Hospital Based)	100% after \$500 copay
Diagnostic, X-ray and Lab (Freestanding Facility)	100% after \$10 copay
Diagnostic, X-ray and Lab (Hospital Based)	100% after \$25 copay
Durable Medical Equipment	70% of RBR
Hearing Aids (under the age of 13)	100%
Hearing Exams (every 24 months)	100% after \$45 copay
Home Health Care	100% after deductible
Hospice Care - Inpatient	\$500 copay after deductible
Hospice Care – Outpatient	100%
Nutritional Counseling	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Pre-Admission Testing	100% after deductible
Private Duty Nursing-Outpatient	100%
Orthotics	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Prosthetics	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Skilled Nursing & Rehabilitative Facilities	\$250 copay
Sleep Studies	100% after deductible
Smoking Cessation Expenses	100%
Tubal Ligation	100%
Telemedicine – MeMD	100%
Vision Exam (every 24 months)	100%
All Other Eligible Medical Expenses	100% after deductible

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Covered Medical Expenses	
Service	
<i>Infertility</i>	
Infertility Diagnostic	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
Infertility Services	Not Covered
<i>Prescription Drugs - Some prescriptions may require preauthorization</i>	
Prescription	Coinsurance/Copay
Non Maintenance Medication: Retail Pharmacy Generic (Up to 30 days)	\$9 copay or less per prescription
Non Maintenance Medication: Retail Pharmacy Brand (Up to 30 days)	70% up to \$300 Maximum
Maintenance Medication: Retail Pharmacy Generic (30/90 days)	\$18/\$54 or less per prescription (After 2 nd Fill)
Maintenance Medication: Retail Pharmacy Brand (30/90 days)	50% up to \$300/\$900 Maximum
Maintenance Medication: Mail Order Generic (Up to 90 days)	\$18 or less per prescription
Maintenance Medication: Mail Order Brand (Up to 90 days)	70% x 2 up to \$600 Maximum
Specialty Medication* (Up to 30 days)	60% up to \$300 Maximum

*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
<i>Medical</i>	
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
Spinal Manipulation	Limited to 20 visits per calendar year
Routine Vision Exam	One exam every 24 months and refraction per calendar year by an Optometrist or Ophthalmologist
<i>Prescription Drugs</i>	
Maximum Supply Retail Pharmacy Prescriptions	90 days
Maximum Supply Mail Order Pharmacy Prescriptions	90 days