FY 2020 HEALTH PLAN BENEFIT OVERVIEW
UNDER THE PARTNERSHIP PLAN, ADMINISTERED BY CENTIVO

MEDICAL COVERAGE (Your costs are outlined in the grid below)	**COORDINATED** Benefit Level	**UNCOORDINATED** Benefit Level
	Your care will be subject to this benefit level when you: (1) utilize a Select Primary Care Physician (PCP), and (2) coordinate your specialty care through your Select PCP. All other care will be considered "uncoordinated".	Your care will be subject to this benefit level when you: (1) utilize a non-Select PCP; and (2) do not coordinate your specialty care with a Select PCP.
Provider network	**None – all doctors, hospitals, and facilities are covered**	
Deductible (individual / family) *Per plan year* **In-network** **Out-of-network**	None	$1,000 / $3,000
Out-of-pocket maximum (individual / family) *Per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum* **In-network** **Out-of-network**	$4,000 / $8,000	$4,000 / $8,000
Coinsurance *Participant pays (after deductible)* **In-network** **Out-of-network**	Outlined below	Outlined below
Preventive care	No charge - plan pays 100%	No charge - plan pays 100%
PCP office visit	No charge	$35 copay (not subject to deductible)
Diagnostic labs if ordered by your PCP	No charge	20% coinsurance (after deductible)
Specialist office visit	$25 copay if care is coordinated	$50 copay (not subject to deductible)
Diagnostic labs if ordered by specialist	20% coinsurance (no deductible)	20% coinsurance (after deductible)
Telemedicine	Not covered	Not covered
High tech radiology (CT scan, MRI, nuclear medicine)	20% coinsurance (no deductible)	20% coinsurance (after deductible)
Other radiology	20% coinsurance (no deductible)	20% coinsurance (after deductible)
Emergency room visit (true emergency use*)	$250 copay	$250 copay (not subject to deductible)
Emergency room visit (non-emergency use)	Not covered	Not covered
Freestanding emergency room visit	$250 copay for true emergency use*, not covered if non-emergency use	$250 copay for true emergency use*, not covered if non-emergency use
Urgent care visit	$25 copay if care is coordinated	$50 copay (not subject to deductible)
Outpatient surgery	No charge for professional services if care is coordinated; $300 copay for facility	20% coinsurance (after deductible)

** A **"true medical emergency"** is when immediate care is required for a life-threatening emergency or accidental bodily injury which untreated could result in death or serious bodily impairment. **"Emergency"** shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, and hemorrhage. Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the plan, that an emergency did exist. The plan may, at its own discretion, request satisfactory proof that an emergency or acute condition did exist. Some example of an emergency are: apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple injuries, convulsions, respiratory distress including asthma attacks, apparent poisoning or severe pain from the sudden onset of an illness. Some example of conditions that are not generally considered an emergency are: colds, influenza, ear infections, nausea or headaches.*

MEDICAL COVERAGE CONTINUED (Your costs are outlined in the grid below)	**COORDINATED** Benefit Level	**UNCOORDINATED** Benefit Level
Inpatient hospital — facility charges only *Pre-authorization required* **In-network** **Out-of-network**	No charge for professional services if care is coordinated; $500 copay for facility for surgical and medical admissions	20% coinsurance (after deductible)
Bariatric surgery — physician charges	Not covered	Not covered
Physical therapy	$25 copay if care is coordinated	20% coinsurance (after deductible)
Chiropractic care	$25 copay if care is coordinated	20% coinsurance (after deductible)
Annual vision exam *One per plan year*	$25 copay if care is coordinated (must be performed by an ophthalmologist)	$50 copay (not subject to deductible; must be performed by an ophthalmologist)
Annual hearing exam	$25 copay (only for children up to the age of 19)	$50 copay (not subject to deductible; only for children up to the age of 19)

PRESCRIPTION COVERAGE

PARTNERSHIP PLAN, ADMINISTERED BY CENTIVO

Drug deductible *Per person, per plan year*	None
Generic drugs — retail or mail order	$10 copay
Brand drugs on formulary	$50 copay
Non-formulary brand drugs	Not covered
Specialty drugs *Up to a 30-day supply. Specialty drugs are restricted to Maxor Specialty Pharmacy.*	20% coinsurance (no deductible)

Notes:

Not all pharmacies will be covered; participants must ensure they are utilizing an in-network pharmacy for their prescriptions under the Partnership Plan.

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