Plan Design For: Associations
Plan Name: Plan 10
Effective Date: January 1, 2025

Signature Date

*The following Benefit Summary is only a brief, non-legal outline of the benefits offered.*

| BENEFITS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MEDICAL AND SURGICAL BENEFITS** | | |
| **Deductible (Embedded*)** | $3,500 Individual / $7,000 Family | $7,000 Individual / $14,000 Family |
| **Coinsurance (**Shown as percentages below) | N/A | $6,000 Individual / $12,000 Family |
| **Standard Out-of-Pocket**<br>Includes Deductible and Coinsurance | N/A | $13,000 Individual / $26,000 Family |
| **Standard Out-of-Pocket: Allowable charges for Coinsurance are paid at 100% after the Standard Out-of-Pocket is met.** | | |
| **In-Network Maximum Out-of-Pocket**<br>Includes Deductible, Co-pays and Coinsurance | $7,350 Individual / $14,700 Family | |
| **Physician Services in the Office**<br>Excluding Obstetrical Delivery, Dialysis Treatment, Chemotherapy, Radiation and Second Surgical Opinion<br><br>Includes Office Surgery, Lab and X-ray. | $30 Primary Care Co-pay, then 100%<br>$60 Specialist Co-pay, then 100%<br><br>Primary Care = General, Family Doctor, Pediatrician, Internist, OB/GYN | Deductible, 50% |
| **Blue CareOnDemand** SM | $30 Co-pay, then 100% | Not Covered |
| **Other Physician Services**<br>Inpatient / Outpatient hospital, allergy injections, anesthesia services, radiology, chemotherapy, dialysis, pathology, obstetrical delivery, initial newborn pediatric exam and all other outpatient / office services | Deductible, 75% | Deductible, 50% |
| **Wellness Benefits** – *Based on the Health Care Reform Guidelines refer to www.healthcare.gov* | 100% | Not Covered |
| **Sustained Health Services** ($500 annual maximum) | $30 Co-pay, then 100% | Not Covered |
| **Annual Physicals and Sustained Health Services are only covered at a Primary Care Provider.** | | |
| **Inpatient Facility Charges** | Deductible, 75% | Deductible, 50% |
| **Skilled Nursing Facility Charges** (60 days per year) | Deductible, 75% | Deductible, 50% |
| **Outpatient Facility Charges** | Deductible, 75% | Deductible, 50% |
| **Other Services**<br>Physical / Occupational Therapy (30 combined visits)<br>Home Healthcare<br>Hospice | Deductible, 75% | Deductible, 50% |
| **Chiropractic Benefits** ($500 annual maximum) | $60 Co-pay, then 100% | Deductible, 50% |
| **Independent Labs** | Deductible, 75% | Deductible, 50% |
| **Ambulance** | Deductible, 75% | In-Network Deductible, 75% |
| **Urgent Care** | $60 Co-pay, then 100% | Deductible, 50% |
| **Emergency Room Facility Charges ****| $300 Co-pay, Deductible, 75% | $300 Co-pay, In-Network Deductible, 75% |
| **Emergency Room Professional Charges ** | Deductible, 75% | In-Network Deductible, 50% |
| **Non-Participating Provider at a Participating Provider Facility (generally includes Ambulance Services, Emergency Services and non-Emergency Services) are subject to In-Network Deductible, Coinsurance and Out-of-Pocket Level. | | |
| **MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS** | | |
| **Inpatient Facility Charges** | Deductible, 75% | Deductible, 50% |
| **Inpatient Professional Charges** | Deductible, 75% | Deductible, 50% |
| **Outpatient Facility Charges** | Deductible, 75% | Deductible, 50% |
| **Outpatient Professional Charges** | Deductible, 75% | Deductible, 50% |
| **Emergency Room Facility Charges** | $300 Co-pay, Deductible, 75% | $300 Co-pay, In-Network Deductible, 75% |
| **Emergency Room Professional Charges** | Deductible, 75% | In-Network Deductible, 75% |
| **Physician Services in the Office** | $30 Co-pay, then 100% | Deductible, 50% |
| **PHARMACY BENEFITS** | | |
| **Prescriptions *Mandatory Generic***<br>(Includes diabetic supplies and oral contraceptives)<br>Retail (31 day supply)***<br>Mail Order (90 day supply) | <br><br>$15 (Generic) / $40 (Preferred) / $70 (Non-Preferred)<br>$25 (Generic) / $90 (Preferred) / $175 (Non-Preferred) | <br><br>50% after Co-pay<br>Not Covered |
| ***Member may purchase a 90 day Supply of a Generic Prescription, however 3 Retail Generic co-pays will apply at the time of purchase. | | |
| **Specialty Drug – Optum Specialty Pharmacy Only**<br>1-877-259-9428 for inquiries regarding this benefit | $125 Co-pay per 31 day supply | Not Covered |
| **BENEFIT MAXIMUMS** | | |
| **Annual / Lifetime Maximum** | Unlimited | |

***Embedded Deductible:** An individual deductible "embedded" within the family deductible. Before the insurance benefits begin the individual must meet the embedded individual deductible amount, which is equal to the single coverage deductible.

## IMPORTANT NUMBERS

Customer Service: 1-800-760-9290
Pre-Authorization: 1-800-327-3238
Pre-Authorization for MRI, MRA, PET, CT & CAT scans: 1-866-500-7664
Pre-Authorization for Mental Health and Substance Abuse (Except Office Services): 1-800-868-1032

## SERVICES AND SUPPLIES THAT ARE NOT PAID FOR

Some services or supplies you receive may not be covered under this health coverage. Expenses for the following will not be paid:

- Any service or supply that is not medically necessary. However, if a service is determined to be not medically necessary because it was not rendered in the least costly setting, covered expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.
- Custodial care. This is care meant simply to help people who cannot take care of themselves.
- Cosmetic or re-constructive procedures, unless following a mastectomy.
- Investigational or experimental services.
- Any treatment for surgery for obesity, weight reduction, weight control or complications there from, reversal or re-constructive procedures resulting from such treatment.
- Services or supplies related to dysfunctional conditions of the muscles of mastication, malposition, or deformities of the jawbone, orthognathic deformities or TMJ (Temporomandibular Joint Disorder including, but not limited to, surgical treatment, appliances and orthodontia.)
- Treatment resulting from acts of war or military service.
- Services you are not charged for in VA hospitals or other kinds of hospitals or agencies.
- Any service or supply provided by a member of the patient's family or by the patient, including the dispensing of drugs. A member of the patient's family means spouse, parent, grandparent, brother, sister, child or spouse's parent.
- Services or supplies you received before you had coverage under this group contract or after you no longer have this coverage.
- Luxury or convenience items and travel expenses, whether or not recommended by a physician.
- Services or supplies payable by Medicare, workers compensation or any other government or private program.
- Private duty services by sitters or companions; private duty services by RNs and LPNs unless these services are part of an approved home health or hospice program.
- Reversals of tubal ligations or vasectomies.
- Prescription drugs bought at a doctor's office, skilled nursing home, hospital or any other place that is not a pharmacy licensed to dispense drugs in the state where it is operated.
- Any service or treatment for complications resulting from any non-covered procedures.
- Any service or supply rendered to a member for diagnosis or treatment of infertility.
- Any service or supply rendered to a member for the diagnosis or treatment to change gender or to improve or restore sexual function.
- Relationship counseling, including marriage counseling, for the treatment of pre-marital, marital or relationship dysfunction.
- Services and supplies related to routine foot care.
- Food supplements, even if the supplements are ordered or prescribed by a physician.
- Prescription drugs used for weight control, obesity, cosmetic purposes, hair growth or fertility.
- Any service or supply the member is not legally obligated to pay.
- Services for the removal of impacted teeth.
- Eyeglasses, contact lenses (except after cataract surgery), hearing aids and examination for the prescription or fitting thereof and any hospital or physician charges related to refractive care.
- Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, unless a part of an approved Applied Behavioral Analysis (ABA) therapy.
- Dental services, except for dental treatment up to 12 months after an accident.
- Services and supplies received for the treatment of any work related accident or illness.
- Cranial Orthotics, except when deemed Medical Necessary.
- Hypnotism
- Pre-conception testing, pre-conception counseling or pre-conception genetic testing

### SERVICES AND SUPPLIES REQUIRING PREAUTHORIZATION

For Pre-Authorization: **Call 1-800-327-3238** for the following Services:

- Durable Medical Equipment over $500, network only
- All inpatient hospital or skilled nursing facility admissions and in-patient psychiatric
- Home health care, hospice care or inpatient physical rehabilitation
- Outpatient psychiatric care, outpatient procedures for Chemotherapy or Radiation Therapy (one-time notification), Hysterectomy, Septoplasty, Sclerotherapy, all Cosmetic procedures, Investigational procedures performed in outpatient or office setting, all inpatient hospital or skilled nursing facility admissions.
- Services and supplies related to human organ and tissue transplants required to use Blue Distinction Centers of Excellence.
- Benefits will be reduced or declined if required pre-authorizations are not obtained.
- To receive pre-authorization for the following procedures: computed tomography (CT), computerized axial tomography (CAT), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA) or positron emission tomography (PET) scans. **Call 1-866-500-7664**
- Mental Health and Substance Abuse Services (except Office Services) must be Pre-Authorized by CBA prior to services being rendered. **Call 1-800-868-1032**

## NOTICE OF OUR PRIVACY POLICIES AND PRACTICES

This Notice has been prepared to inform you that we do not disclose and we reserve no right to disclose to our affiliates or to nonaffiliated third parties, your nonpublic personal financial information, which we collect and maintain except with your permission or as permitted by law. We will not disclose your nonpublic personal financial information except as described in this Notice even if our customer relationship with you may end.

If you a plan sponsor or group policyholder, this Privacy Notice describes our practices for safeguarding nonpublic personal financial information about employee benefit plan participants and beneficiaries.

**Information we collect and maintain**: We collect nonpublic personal financial information about you from the following sources:

- Information we receive from you on applications, at your request or otherwise;
- Information we obtain from your transactions with us, our affiliates or others;
- Information we receive from consumer-reporting agencies.

**How we protect information**: Except as otherwise described in this Notice, we restrict access to your nonpublic personal financial information to our employees who need to know to provide our products and services to you and as permitted by law. We maintain physical, electronic, and procedural safeguards that comply with applicable legal requirements to guard your nonpublic personal financial information. We have installed usernames, passwords and other safety features on our Web applications to help ensure that the information you provide remains safe and secure.

**Changes to this Notice**: We may amend our privacy policies and practices at any time, and we will inform you of any material changes as required by law.

**You do not need to do anything in response to this notice. This notice is merely to inform you about our privacy policies and practices.**

Plan Design For: Association
Plan Name: Plan 10
Effective Date: January 1, 2025

| Coverage Tier | Rates |
|---|---|
| **Individual** | **$** |
| **Family** | **$** |
| **Employee Plus Children** | **$** |
| **Employee Plus Spouse** | **$** |

**Rates include ___% commission.**

**Based upon the employee data you provided, we guarantee the availability of the proposed benefits at the rates quoted above until December 31, 2024 based upon the completion and acceptance of an employer supplemental questionnaire that is signed by an official of the group. If enrollment data varies by 15% or more, we reserve the right to adjust rates accordingly. Rates are based on 75% participation of eligible employees.**

Signature Date

# Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

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Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

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如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

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Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

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이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

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Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

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Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

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إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

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Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

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Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

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Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

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Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

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Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

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あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

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Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

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اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

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Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)