

PIEDMONT HEALTH COALITION
Basic Plan

Plan Feature	Network Benefit	Out-of-Network Benefit
LIFETIME MAXIMUM Except for Chemical Dependency and/or Substance Abuse Conditions	\$1,000,000	\$1,000,000
CALENDAR YR. DEDUCTIBLE	Single = \$250 / Family = \$750	Single = \$750 / Family = \$2,250
Applicable to Calendar Year Deductible:		
<ul style="list-style-type: none"> · Outpatient Hospital Expenses · Maternity (prenatal/outpatient services) · Diagnostic X-Rays & Labs · Convalescent Facility Expenses · Private Duty Nursing · Chemical Dependency/Substance Abuse Disorders 	<ul style="list-style-type: none"> · Chiropractic Care · Fertility Testing · Short-Term Rehab · Ambulance · Anesthetics · DME & Oxygen · Prosthetics · Hearing Aids 	<ul style="list-style-type: none"> · Surgery · Partial Hospitalization · Inpatient Hospital Services · Speech Therapy · Home Health · Hospice · Allergy Testing
COINSURANCE LIMIT Maximum Out of Pocket	Single = \$1,500/Family = \$3,000	Single = \$3,000/Family = \$6,000
PHYSICIAN OFFICE VISITS PRIMARY CARE <ul style="list-style-type: none"> · Excludes X-Ray & Labs · Excludes Chemical Dependency and/or Substance Abuse 	\$25 Copay	60% Coinsurance after Calendar Year Deductible
PHYSICIAN OFFICE VISIT SPECIALIST <ul style="list-style-type: none"> · Excludes X-Ray and Lab Services · Excludes Chemical Dependency and/or Substance Abuse 	\$25 Copay	60% Coinsurance after Calendar Year Deductible
ROUTINE WELL CHILD EXAM & IMMUNIZATION <ul style="list-style-type: none"> · Up to age 6 · Maximum \$500/Child 	\$25 Copay	60% Coinsurance after Calendar Year Deductible
INPATIENT DEDUCTIBLE <ul style="list-style-type: none"> · Per Admission with no calendar limits · Waived for newborns except when greater than mother's stay 	\$200	\$450 \$600 for Tertiary Hospital (\$600.will apply if services could have been provided by ARMC)
DIAGNOSTIC X-RAYS, LABORATORY, ALLERGY TESTING and ALLERGY MEDICATIONS – Unrelated to Office Visit	80% Coinsurance after Calendar Year Deductible	60% Coinsurance after Calendar Year Deductible
HOSPITAL EXPENSES → Conditions OTHER than Mental, Nervous, or Substance Abuse <ul style="list-style-type: none"> · Inpatient · Outpatient 	<ul style="list-style-type: none"> 80% Coinsurance after Inpatient Deductible 80% Coinsurance after Calendar Year Deductible 	<ul style="list-style-type: none"> 60% Coinsurance after Inpatient Deductible 60% Coinsurance after Calendar Year Deductible
HOSPITAL EMERGENCY ROOM <ul style="list-style-type: none"> · Waived if admitted within 24 hours 	\$75 Copay	\$150 Copay \$75 if out of town on business

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MATERNITY <ul style="list-style-type: none"> · Prenatal – Outpatient · Inpatient 	80% Coinsurance after Calendar Year Deductible 80% Coinsurance after Inpatient Deductible	60% Coinsurance after Calendar Year Deductible 60% Coinsurance after Inpatient Deductible
SURGERY (other than office visit)	80% Coinsurance after Calendar Year Deductible	60% Coinsurance after Calendar Year Deductible
SPEECH THERAPY <ul style="list-style-type: none"> · Lifetime Maximum = \$15,000 · Services must be provided by qualified speech therapist for medically determinable conditions 	80% Coinsurance after Calendar Year Deductible	60% Coinsurance after Calendar Year Deductible
CONVALESCENT FACILITY EXPENSES <ul style="list-style-type: none"> · 3 days of prior hospitalization required. · Must begin within 14 days following end of confinement · Maximum 60 days/calendar year 	80% Coinsurance after Calendar Year Deductible	60% Coinsurance after Calendar Year Deductible
HOME HEALTH CARE <ul style="list-style-type: none"> · Prior hospital confinement NOT required · Nurses Aide Visits 4 Hours = 1 Visit · Maximum 100 Visits/Calendar Year 	80% Coinsurance after Calendar Year Deductible	60% Coinsurance after Calendar Year Deductible
HOSPICE EXPENSES	80% Coinsurance after Calendar Year Deductible	80% Coinsurance after Calendar Year Deductible
CHIROPRACTIC CARE Maximum \$500 /Calendar Year	80% Coinsurance after Calendar Year Deductible	80% Coinsurance after Calendar Year Deductible
FERTILITY TESTING <ul style="list-style-type: none"> · Minimum 12 months coverage under this Plan · Family Maximum = \$25,000 	80% Coinsurance after Calendar Year Deductible	60% Coinsurance after Calendar Year Deductible
HEARING AIDS <ul style="list-style-type: none"> · Initial device{s} covered only if necessary to restore hearing lost due to accidental injury while covered under the Plan 	80% Coinsurance after Calendar Year Deductible	80% Coinsurance after Calendar Year Deductible
PRIVATE DUTY NURSING (RN Only) <ul style="list-style-type: none"> · Maximum 70 shifts/calendar year. · 1 shift = 8 hours of Private Duty Nursing by RN only 	80% Coinsurance after Calendar Year Deductible	60% Coinsurance after Calendar Year Deductible
AMBULANCE	80% Coinsurance after Calendar Year Deductible	80% Coinsurance after Calendar Year Deductible
ANESTHETICS	80% Coinsurance after Calendar Year Deductible	80% Coinsurance after Calendar Year Deductible
DURABLE MEDICAL EQUIPMENT & OXYGEN <ul style="list-style-type: none"> · Coverage for rental up to purchase price 	80% Coinsurance after Calendar Year Deductible	80% Coinsurance after Calendar Year Deductible
SHORT-TERM REHABILITATION Maximum 60 days/calendar year	80% Coinsurance after Calendar Year Deductible	80% Coinsurance after Calendar Year Deductible

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PRECERTIFICATION - INPATIENT → Conditions OTHER than Mental, Nervous or Substance Abuse <ul style="list-style-type: none"> · Precertification requested & approved · Precertification requested & denied (stay not necessary) · Precertification not requested 	<p align="center">No Penalty 80% Coinsurance after Inpatient Deductible</p> <p align="center">\$500 Penalty + 80% Coinsurance after Inpatient Deductible</p> <p align="center">\$500 Penalty + 80% Coinsurance after Inpatient Deductible</p>	<p align="center">No Penalty 60% Coinsurance after Inpatient Deductible</p> <p align="center">\$500 Penalty + 60% Coinsurance after Inpatient Deductible</p> <p align="center">\$500 Penalty + 60% Coinsurance after Inpatient Deductible</p>
PRECERTIFICATION - OUTPATIENT Required for all Designated Procedures Conditions OTHER than Mental, Nervous or Substance Abuse <ul style="list-style-type: none"> · Precertification requested & approved · Precertification requested & procedure deemed appropriate · Precertification not requested & procedure deemed unnecessary 	<p align="center">80% Coinsurance after Calendar Year Deductible</p> <p align="center">70% Coinsurance after Calendar Year Deductible</p> <p align="center">NO COVERAGE</p>	<p align="center">60% Coinsurance after Calendar Year Deductible</p> <p align="center">60% Coinsurance after Calendar Year Deductible</p> <p align="center">NO COVERAGE</p>

TREATMENT FOR MENTAL or NERVOUS CONDITIONS		
OFFICE VISITS <ul style="list-style-type: none"> · Treatment by MD (including Psychiatrist) or Psychologist (PhD) · Maximum 25 Visits per calendar year 	<p>\$25 Copay</p>	<p>25% Coinsurance after Calendar Year Deductible</p>
PRECERTIFICATION – INPATIENT → Days must be precertified and under case management → Maximum 10 days per calendar year <ul style="list-style-type: none"> · Precertification requested & approved · Precertification requested & denied (stay not necessary) · Precertification not requested → PARTIAL HOSPITALIZATION <ul style="list-style-type: none"> · Outpatient Program · Conversion to Inpatient Day Limit 	<p align="center">No Penalty 80% Coinsurance after Inpatient Deductible</p> <p align="center">\$500 Penalty + 80% Coinsurance after Inpatient Deductible</p> <p align="center">\$500 Penalty + 80% Coinsurance after Inpatient Deductible</p> <p align="center">80% Coinsurance after Calendar Year Deductible</p> <p align="center">2 for 1</p>	<p align="center">No Penalty 25% Coinsurance after Inpatient Deductible</p> <p align="center">\$500 Penalty + 25% Coinsurance after Inpatient Deductible</p> <p align="center">\$500 Penalty + 25% Coinsurance after Inpatient Deductible</p> <p align="center">25% Coinsurance after Calendar Year Deductible</p> <p align="center">1 for 1</p>

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TREATMENT FOR CHEMICAL DEPENDENCY or SUBSTANCE ABUSE		
LIFETIME MAXIMUM - Chemical Dependency or Substance Abuse	\$10,000/Individual \$20,000/Family	\$10,000/Individual \$20,000/Family
OFFICE VISITS <ul style="list-style-type: none"> · Treatment by MD (including Psychiatrist) or Psychologist (PhD) · Maximum 25 Visits per calendar year 	\$25 Copay	25% Coinsurance after Calendar Year Deductible
PRECERTIFICATION - INPATIENT <ul style="list-style-type: none"> → Days must be precertified and under case management → Maximum 10 days per calendar year · Precertification requested & approved · Precertification requested & denied (stay not necessary) · Precertification not requested → <u>PARTIAL HOSPITALIZATION</u> <ul style="list-style-type: none"> · Intensive Outpatient · Outpatient Hospital & Inpatient Physician · Intensive Outpatient Conversion to Inpatient Day Limit 	No Penalty 80% Coinsurance after Inpatient Deductible \$500 Penalty + 80% Coinsurance after Inpatient Deductible \$500 Penalty + 80% Coinsurance after Inpatient Deductible 80% Coinsurance after Calendar Year Deductible 50% Coinsurance after Calendar Year Deductible 3 for 1	No Penalty 25% Coinsurance after Inpatient Deductible \$500 Penalty + 25% Coinsurance after Inpatient Deductible \$500 Penalty + 25% Coinsurance after Inpatient Deductible 25% Coinsurance after Calendar Year Deductible 25% Coinsurance after Calendar Year Deductible 2 for 1

Blue notations may be customized by Plan Sponsor. A coinsurance differential of 20% must be maintained between Network and Out of Network benefits.

OTHER:

- 1) Non-Duplication of Benefits is recommended rather than Coordination of Benefits
- 2) Plan Sponsor (employer) may customize prenatal education and incentives for their employees
- 3) Plan Sponsor (employer) is responsible for HIPAA compliance within Plan Document
- 4) Plan Sponsor (employer) may select its prescription manager or utilize PHC's preferred prescription management vendor – Express Scripts.