




**2018**  
**EXCLUSIVE CARE**  
**SUMMARY OF COVERED BENEFITS**  
 Select Plan for Medicare Eligible Coordination Health Plan



Summary Table of Benefits	Tier 1 Exclusive Care Provider	Tier 2 All Other Providers
Calendar Year Deductible	\$250/person \$750/family	\$500/person \$1,500/family
Calendar Year Out-of-Pocket Maximum	\$1,500/person \$4,500/family	\$2,500/person \$7,500/family
Maximum Lifetime Benefit	None	
<b>Prescription Drug Benefits</b>		
Participating Retail pharmacy (up to a 30-day supply)	Tier 1: \$15 copayment Tier 2: \$25 copayment Tier 3: \$40 copayment ( <b>Prior Authorization is Required</b> )	
<b>If you use Exclusive Care's Rubidoux Pharmacy you can receive up to 3 months            (90 days) of medication for 2 copayments</b>		
Exclusive Care Rubidoux Mail-Order pharmacy (up to a 90-day supply)  	Tier 1: \$30 copayment Tier 2: \$50 copayment Tier 3: \$80 copayment ( <b>Prior Authorization is Required</b> )  <i>Mail-order is available for MAINTENANCE MEDICATIONS after the first 30-day prescription trial.</i>  Please review the Summary Plan description for more details about maintenance medications.	
<b>Hospital/Facility Benefits</b>		
Inpatient Medical/ Maternity/ Surgical Intensive Care (semi-private room)	Subject to prior authorization.	
	90% of network contracted rate	80% of Allowable Charges
Inpatient Medical/ Maternity/ Surgical Intensive Care (ancillary)	Subject to prior authorization.	
	90% of network contracted rate	80% of Allowable Charges
Transplants / Orthopedic / Cardio Vascular / Oncology	Subject to prior authorization.	

Summary Table of Benefits	Tier 1 Exclusive Care Provider	Tier 2 All Other Providers
	90% of network contracted rate	80% of Allowable Charges
Skilled Nursing Facility Maximum of 100 days per year	Subject to prior authorization.	
	90% of network contracted rate	80% of Allowable Charges
Outpatient Medical/Surgical Care	Subject to prior authorization.	
	90% of network contracted rate	80% of Allowable Charges
<b>Physician and Professional Services</b>		
Physician Office Visits (Primary Care)	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply
Physician Office Visits (After Hours)	\$20 copayment; Deductible does not apply	\$50 copayment; Deductible does not apply
Physician Office Visits (Specialty Care)	\$20 copayment; Deductible does not apply	\$50 copayment; Deductible does not apply
Inpatient Physician Visits	\$10 copayment; Deductible	\$25 copayment; Deductible does not apply
Outpatient Physician Visits (including emergency room)	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply
Maternity Care	90% of network contracted	80% of Allowable Charges
Anesthesiology – inpatient and outpatient	90% of network contracted rate	80% of Allowable Charges
Immunizations and Injections	No copayment; Deductible does not apply	No copayment; Deductible does not apply
Allergy Testing	90% of network contracted	80% of Allowable Charges
Allergy Treatment/Serum	90% of network contracted	80% of Allowable Charges
Family Planning – tubal ligation, elective abortion, vasectomy	90% of network contracted rate	80% of Allowable Charges

Summary Table of Benefits	Tier 1 Exclusive Care Provider	Tier 2 All Other Providers
Infertility Treatment	Not covered	
<b>Surgical Procedures</b>		
<b>Subject to prior authorization.</b>		
Office	90% of network contracted rate	80% of Allowable Charges
Inpatient	90% of network contracted rate	80% of Allowable Charges
Outpatient (including ER)	90% of network contracted rate	80% of Allowable Charges
Bariatric Surgery	Not covered	
<b>Other Medical Services</b>		
Members Requiring Diabetes Care	Pharmacy Copays are waived for all Generic and Preferred Brand Name injectable and oral Anti-Diabetic medications and Diabetic supplies (testing strips, syringes, etc.)	
Members taking Anti-Hyperlipidemic and antihypertensive Drugs	Pharmacy Copays are waived for all Generic and Preferred Brand Name Anti-Hyperlipidemic and antihypertensive drugs.	
Home Health Care (instead of in-patient hospital care) Maximum of 26 days per year	Subject to prior authorization.	
	90% of network contracted rate	80% of Allowable Charges
Hospice Care	Subject to prior authorization.	
	90% of network contracted rate	80% of Allowable Charges
<b>Preventive Care Services</b>		
Annual Physical Exams - Preventive screening and any additional preventative services covered by Medicare	No copayment; Deductible does not apply	No copayment; Deductible does not apply
Annual Well Woman Care	No copayment; Deductible does not apply	No copayment; Deductible does not apply
Well Baby	No copayment; Deductible does not apply	No copayment; Deductible does not apply
Annual Vision Exams	No copayment; Deductible does not apply	No copayment; Deductible does not apply

### Hearing Care Benefits

Routine Hearing Exams	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply
Hearing Test (Audiology Exam)	90% of network contracted rate	80% of Allowable Charges
Hearing Aids Limited to \$3000 every 3 years	90% of network contracted rate	80% of Allowable Charges

### Accident & Emergency Benefits

**Benefit payment for emergency admission subject to notification for authorization within 48 hours, next business day, or when medically possible, whichever is earliest.**

Emergency Room & Care	\$50 copayment, then 90% of network contracted rate; Deductible does not apply.	\$100 copayment, then 80% of network contracted rate; Deductible does not apply.
Urgent Care Clinic	\$20 copayment; Deductible does not apply.	\$50 copayment; Deductible does not apply.
Ambulance – Land/Air (life-threatening situations only)	90% of network contracted rate	80% of Allowable Charges
Dental Injury Treatment	Not covered	
Orthodontic Injury Treatment	Not covered	

### Diagnostic Testing Benefits

Major Diagnostic Testing, CT Scan, MRI, NMR	Subject to prior authorization.	
	90% of network contracted rate	80% of Allowable Charges
Minor Diagnostic Test, X-Ray or Lab Test	90% of network contracted rate	80% of Allowable Charges
Radiology/Pathology – inpatient, outpatient or ER	90% of network contracted rate	80% of Allowable Charges

### Rehabilitation Therapy Benefits

Physical, Speech, Occupational	Subject to prior authorization and any therapy cap or threshold	
	90% of network contracted	80% of Allowable Charges
Cardiac or Pulmonary Therapy –	Subject to prior authorization.	
	90% of network contracted	80% of Allowable Charges
Chiropractic Therapy	Not covered	

### Medical Supplies & Equipment

Medical Supplies (Physician's office)	90% of network contracted rate	80% of Allowable Charges
Other Medical Supplies	90% of network contracted rate	80% of Allowable Charges
Durable Medical Equipment	90% of network contracted rate	80% of Allowable Charges

Orthotic Supplies	Not covered	
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### Mental Health

**Subject to prior authorization. Mandatory Centers of Excellence apply.**

Inpatient Facility Care (semi-private room)	90% of network contracted rate	80% of Allowable Charges
Inpatient Facility Care (ancillary)	90% of network contracted rate	80% of Allowable Charges
Inpatient Facility Physician Visits	90% of network contracted rate	80% of Allowable Charges

Outpatient Office Visits (psychologist, psychiatrist, MSCW, and APRN)	\$20 copayment; benefits limited to 30 visits per calendar year unless the condition is a Severe Mental Illness (see Glossary), in which case treatment is covered as for any other illness	Not covered
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Substance Abuse	Subject to prior authorization.	
Inpatient Program – maximum 90 days per lifetime	90% of network contracted rate	80% of Allowable Charges
Inpatient Detoxification – 3 to 5 days as Medically Necessary, 1 episode per lifetime	90% of network contracted rate	80% of Allowable Charges
Outpatient Hospital Services	\$20 copayment; limited to 30 visits per calendar year	
Outpatient Office Visits (psychologist, psychiatrist, MSCW, and APRN)	\$20 copayment; limited to 30 visits per calendar year	

To learn more about what other services available to you, please visit our website at [www.exclusivecare.com](http://www.exclusivecare.com)

**“Working to Keep you Healthy!”**

