



2018



EXCLUSIVE CARE HEALTH PLAN

SUMMARY OF COVERED BENEFITS (Network Only)

THIS IS ONLY A BRIEF SUMMARY. PLEASE REFER TO THE SUMMARY PLAN DOCUMENT (SPD) FOR FURTHER EXPLANATION AND HOW TO OBTAIN SERVICES.


Choice of Physician	Any Participating Primary Care Physician
Deductible – Individual	None
Deductible – Family	None
Out-of-Pocket Maximum	\$1,500/Member, maximum \$3,000/Family per Calendar Year
Lifetime Maximum Benefit	Unlimited
Pre-existing Condition	Fully Covered
Outpatient/Office Visits	Coverage Level
Physician Office Visits	100% after \$15 Copay
Hospital Clinic Visits	100% after \$15 Copay
Immunizations	100%
Maternity Care	100%
Periodic Health Evaluations	100%
Diagnostic X-ray & Lab	100%
Well Baby Care	100%
Well Woman Care	100%
Vision Exams (screening and refraction)	100%


Outpatient Prescription Drugs

Prescription Drug Coverage is administered by the Plan's Pharmacy Benefit Manager (PBM)

Participating Retail Pharmacy (up to a 30-day supply)	FORMULARY DRUGS	<u>1-30 days</u>
	Generic Drugs	\$10 Copay
	Preferred Brand Name Drugs	\$25 Copay
	Non-Preferred Brand Name Drugs	\$50 Copay
	<p>Significant or new therapeutic class drugs: 50% copay</p> <p>Some formulary and all non-formulary drugs require pre-authorization</p> <p>Members with Diabetes and Members who use Anti-Hyperlipidemic and antihypertensive drugs receive additional benefits as described in "Other Benefits".</p>	

If you use Exclusive Care's Rubidoux Pharmacy you can receive up to 3 months (90 days) of medication for only 2 Copays (saving you 1 Copay)

Exclusive Care Rubidoux Pharmacy (up to a 90-day supply) 	FORMULARY DRUGS	1-30 days	90 days
	Generic Drugs	\$10 Copay	\$20 Copay
	Preferred Brand Name Drugs	\$25 Copay	\$50 Copay
	Non-Preferred Brand Name Drugs	\$50 Copay	\$100 Copay
Significant or new therapeutic class drugs: 50% copay Some formulary and all non-formulary drugs require pre-authorization. Members with Diabetes and Members who use Anti-Hyperlipidemic and antihypertensive drugs receive additional benefits as described in "Other Benefits".			

Exclusive Care Rubidoux Pharmacy Mail-Order Prescriptions  (up to a 90-day supply)	FORMULARY DRUGS	90 days
	Generic Drugs	\$20 Copay
	Preferred Brand Name Drugs	\$50 Copay
	Non-Preferred Brand Name Drugs	\$100 Copay
<p><i>Mail-Order is available for maintenance medications after the first 30-day prescription trial</i></p> Significant or new therapeutic class drugs: 50% copay Some formulary and all non-formulary drugs require pre-authorization Members with Diabetes and Members who use Anti-Hyperlipidemic and antihypertensive drugs receive additional benefits as described in "Other Benefits".		

Hospital & Emergency Room

Ambulance	100%
Ambulatory Surgical Center	100% at Network facility only
Physician Hospital Visits	100%
Inpatient Hospital Services	\$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review).
Outpatient Hospital Services	100% at Network facility only; non-Network facilities not covered
Hospital Emergency Room (Copay waived if admitted)	100% after \$100 copay at both network and non-network ERs. <u>(services subject to medical review for approval)</u>
Urgent Care/Urgently Needed Services	100% after \$20 Copay at Network or non network facility. (services subject to medical review for approval)

Severe Mental Health Treatment

Inpatient Care	\$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review).
Outpatient Care	100% after \$15 Copay

Non-Severe Mental Health Treatment

Inpatient Care	\$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review).
Outpatient Care - Individual	100% after \$15 Copay
Outpatient Care - Group	100% after \$15 Copay

Substance Abuse Treatment

Inpatient Care	\$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review).
Inpatient Detoxification	\$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review).
Outpatient Hospital Services	100% at Network facility only
Outpatient Office Visit	100% after \$15 Copay

Other Benefits

Allergy Testing & Treatment	100% after \$15 Copay
Chiropractic Care	100% after \$15 Copay; benefits limited to 12 visits/Calendar Year
Members Requiring Diabetes Care	Pharmacy Copays are waived for all Generic and preferred injectable and oral Anti-Diabetic medications and Diabetic supplies (testing strips, syringes, etc.)
Durable Medical Equipment	50% Copay (services subject to medical review for approval)
Members taking Anti-Hyperlipidemic and antihypertensive Drugs	Pharmacy Copays are waived for all Generic and Preferred Brand Name Anti-Hyperlipidemic and antihypertensive drugs
Other Medical Equipment (As defined in Section 4: Outpatient Services)	100%
Family Planning	
Elective Pregnancy Termination	100% after \$50 Copay for 1 st trimester; \$100 Copay for 2 nd trimester; (3 rd trimester only covered if pregnancy life threatening to mother)
Infertility Services	50% Copay; up to a maximum of \$10,000 lifetime benefit
Tubal Ligation	100%
Vasectomy	100%

Home Health Care	100%
Hospice Care	100%
Physical Therapy	100% after \$15 Copay up to 30 visits/disability within a 90-day period
Skilled Nursing Facility	100% up to 100 days/Disability
Hearing Aid Instrument	\$3,000/Member; once every 36 months
Bariatric Surgery	\$100 per admission at Network facility only (services subject to medical review for approval)

To learn more about what other services available to you,
please visit our website at www.exclusivecare.com

“Working to Keep you Healthy!”

