



2019




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)	<table border="0"> <tr> <td>FORMULARY DRUGS</td> <td style="text-align: right;"><u>1-30 days</u></td> </tr> <tr> <td>Generic Drugs</td> <td style="text-align: right;">\$10 Copay</td> </tr> <tr> <td>Preferred Brand Name Drugs</td> <td style="text-align: right;">\$25 Copay</td> </tr> <tr> <td>Non-Preferred Brand Name Drugs</td> <td style="text-align: right;">\$50 Copay</td> </tr> <tr> <td colspan="2">Significant or new therapeutic class drugs: 50% copay</td> </tr> <tr> <td colspan="2">Some formulary and all non-formulary drugs require pre-authorization</td> </tr> <tr> <td colspan="2">Members with Diabetes and Members who use Anti-Hyperlipidemic and antihypertensive drugs receive additional benefits as described in “Other Benefits”.</td> </tr> </table>	FORMULARY DRUGS	<u>1-30 days</u>	Generic Drugs	\$10 Copay	Preferred Brand Name Drugs	\$25 Copay	Non-Preferred Brand Name Drugs	\$50 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”.	
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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	<u>1-30 days</u>	<u>90 days</u>
	Generic Drugs Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	\$10 Copay \$25 Copay \$50 Copay	\$20 Copay \$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	<u>90 days</u>
	Generic Drugs Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	\$20 Copay \$50 Copay \$100 Copay
<i>Mail-Order is available for maintenance medications after the first 30-day prescription trial</i> 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 per admission 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 please visit our websites at:

www.exclusivecare.com

or

www.exclusivecare.com/healthyhighways/

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