



2017



**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.*


<b>Choice of Physician</b>	<b>Any Participating Primary Care Physician</b>
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
<b>Outpatient/Office Visits</b>	<b>Coverage Level</b>
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)	<b>FORMULARY DRUGS</b>	<b><u>1-30 days</u></b>
	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".	

**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)  	<b>FORMULARY DRUGS</b>	<b>1-30 days</b>	<b>90 days</b>
	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  <b>Mail-Order Prescriptions</b>    (up to a 90-day supply)	<b>FORMULARY DRUGS</b>	<b>90 days</b>
	Generic Drugs	\$20 Copay
	Preferred Brand Name Drugs	\$50 Copay
	Non-Preferred Brand Name Drugs	\$100 Copay

***Mail-Order is MANDATORY for maintenance medications after the first 30-day prescription trial***

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".

<b>Hospital &amp; Emergency Room</b>	
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. <b><u>(services subject to medical review for approval)</u></b>
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 <sup>st</sup> trimester; \$100 Copay for 2 <sup>nd</sup> trimester; (3 <sup>rd</sup> 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](http://www.exclusivecare.com)

**“Working to Keep you Healthy!”**

