PLAN SUMMARY_IH-Nova

GENERAL INFORMATION	Medical/Rx Plan Comparison					
Plan Type	TRADITIONAL		CORE		PROGRESSIVE	
Network Indicator	Nova		Nova		Nova	
Benefit Summary	Medical/Rx PPO & POS		Medical/Rx PPO & POS		Medical/Rx PPO & POS	
BENEFIT SUMMARY	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible/Individual	$0	$1,000	$0	$2,000	$300 per person per cal yr. combined Medical & Rx	$3,000
Annual Deductible/Family	$0	$2,000	$0	$5,000		$6,000
Coinsurance	None	30%	None	30%	None	30%
Annual Out-of-Pocket Limit/Individual	$5,000	$9,500	$5,000	$9,500	$5,000	$19,000
Annual Out-of-Pocket Limit/Family	$10,000	$19,000	$10,000	$19,000	$10,000	$38,000
Deductible Included in Out-of-Pocket Limits	N/A	Yes	N/A	Yes	Yes	Yes
Medical Services/Benefits						
Office Visit/Exam	Covered in Full	30% after ded.	$10 Copayment	30% after ded	$15 Copayment after deductible	Not Covered
Specialist Visit	Covered in Full	30% after ded.	$10 Copayment	30% after ded.	$15 Copayment after deductible	Not Covered
Preventive Care/Screening	Covered in Full	30% after ded.	Covered In Full	30% after ded.	Covered In Full	Not Covered
Emergency Room Services	$300 Copayment *		$400 Copayment*		$250 Copayment after Deductible*	
Urgent Care	Covered in Full	Covered in Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Ambulance	$25 Copayment	$25 Coinsurance	$50 Copayment	$50 Copayment	$50 Copayment	$50 Copayment
Inpatient Hospital Services	Covered in Full	30% after ded.	Covered in Full	30% after ded.	$500 Copayment	Not Covered
Outpatient Surgery	Covered in Full	30% after ded.	$75 Copayment; applied to facility charge & physician in office setting	30% after ded.	$75 Copayment; applied to facility charge & physician in office setting	Not Covered
Outpatient Physical, Occupational, Speech Therapy	Covered in Full	30% after ded.	Covered In Full	30% after ded.	$15 Copayment after deductible Limited to 20 visits each	Not Covered
Home Health Care	Covered in full Limited 40 visits per calendar yr	30% after ded.	Covered in full Limited 40 visits per calendar yr	30% after ded.	$15 Copayment after deductible Limited to 40 visits per calendar yr	Not Covered
Durable Medical Equipment	50%	50% after ded.	50%	50% after ded.	50% after ded.	50% after ded.
Skilled Nursing Care	Covered in Full Limited to 45 days per calendar yr	30% after ded.	Covered in Full Limited to 45 days per calendar yr	30% after ded.	$500 Copayment for Inpatient; $15 Copayment for Outpatient Limited to 45 days per calendar yr	Not Covered
Inpatient Mental Health/Substance Abuse	Covered in Full	30% after ded.	Covered in Full	30% after ded.	$500 Copayment	Not Covered
Outpatient Mental Health/Substance Abuse	Covered in Full	30% after ded.	$10 Copayment for office visit	30% after ded.	$15 Copayment after deductible	30% after deductible
Maternity Care	Covered in Full	30% after ded.	Covered in Full	30% after ded.	$15 copayment after ded. for outpt services; $500 Copayment for inpatient	Not Covered
Laboratory Services	Covered in Full	30% after ded.	Covered in Full	30% after ded.	Covered In Full	30% after deductible
Radiology (diagnostic)	Covered in Full	30% after ded.	$15 copayment	30% after ded.	$15 copayment after ded.	30% after deductible
Chiropractic Services	Covered in Full	30% after ded.	$15 copayment	30% after ded.	$15 copayment after ded.	Not Covered
Diabetic Supplies	Covered in Full	30% after ded.	Covered in Full	30% after ded.	Subject to deductible; then subject to Rx copays	Not Covered
Telemedicine Visit	Covered in Full	30% after ded.	Covered in full	30% after ded.	$15 copayment after ded.	Not covered
Medical Eye Exam	Covered in Full	30% after ded.	$10 Copayment	30% after ded.	$15 copayment after ded.	Not Covered

PLAN SUMMARY_IH-Nova

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Benefit Summary	Medical/Rx PPO & POS		Medical/Rx PPO & POS		Medical/Rx PPO & POS	
BENEFIT SUMMARY	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Benefits						
Prescription Drug Deductible						
Retail - 30 day supply						
Generic / Tier 1	$0 Copayment	Not Covered	$5 Copayment	Not Covered	$5 Copayment	Not Covered
Brand (Formulary/Preferred) / Tier 2	$15 Copayment	Not Covered	$25 Copayment	Not Covered	$40 Copayment	Not Covered
Brand (Non-Formulary/Non-preferred) / Tier 3	$30 Copayment	Not Covered	$60 Copayment	Not Covered	$75 Copayment	Not Covered
Specialty / Tier 4	Paid according to applicable Tier; Participants are required to utilize the Payer Matrix program	Not Applicable	Paid according to applicable Tier; Participants are required to utilize the Payer Matrix program	Not Applicable	7% Coinsurance after deductible to a maximum of $120 for 30 day supply; Participants are required to utilize the Payer Matrix program	Not Applicable
Mail Order - 90 day supply	Mandatory Mail after 2nd fill at Retail		Mandatory Mail after 2nd fill at Retail		Mandatory Mail after 2nd fill at Retail	
Generic / Tier 1	$0 Copayment	Not Covered	$12.50 Copayment	Not Covered	$12.50 Copayment	Not Covered
Brand (Formulary/Preferred) / Tier 2	$37.50 Copayment	Not Covered	$62.50 Copayment	Not Covered	$100 Copayment	Not Covered
Brand (Non-Formulary/Non-preferred) / Tier 3	$75 Copayment	Not Covered	$150 Copayment	Not Covered	$187.50 Copayment	Not Covered
Vision Benefits	Must use EyeMed Provider		Must use EyeMed Provider		Must use EyeMed Provider	
Routine Eye Exam	Covered in Full; One exam every 12 months	Not Covered	$10 Copayment; One exam every 12 months	Not Covered	Subject to deductible, then $15 copayment	Not Covered
Frames	60% of Retail Price; One set every 12 months	Not Covered	60% of Retail Price; One set every 12 months	Not Covered	Not Covered	Not Covered
Lenses	Single $50 copay Bifocal $70 copay Trifocal $105 copay Lenticular $105 copay Progressive $135 copay Once every 12 months	Not Covered	Single $50 copay Bifocal $70 copay Trifocal $105 copay Lenticular $105 copay Progressive $135 copay Once every 12 months	Not Covered	Not Covered	Not Covered
Contact Lenses	15% discount (applies to materials only)	Not Covered	15% discount (applies to materials only)	Not Covered	Not Covered	Not Covered
Laser Vision Correction	15% discount off standard fees or 5% off promotional fees; Must use U.S. Laser Network for LASIK or PRK	Not Covered	15% discount off standard fees or 5% off promotional fees; Must use U.S. Laser Network for LASIK or PRK	Not Covered	Not Covered	Not Covered
Children's Eye Care	Eye exam - Covered in full $40 copayment, 10% discount on balance of frames over $70	Not Covered	$10 Copayment for exam; Glasses subject to $40 copayment, 10% discount on balance of frames over $70	Not Covered	$15 Copayment for Eye exam; Eye glasses not covered	Not Covered

* Copayments are waived if admitted or for certain long-term observation holds; capped at two times copayment in the event a common accident or injury occurs for a family unit at the same time.

NY44 Health Trust Benefits Plan