THE EVOLUTION OF HEALTH PLAN INTEGRATION

# PRECIS PLAN

## SUMMARY OF PLAN COVERAGES

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.

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# PRECIS PLAN
INTEGRATED HEALTH PLANS

| Medical Provisions | PRECIS500 In-Network | PRECIS500 Out-of-Network | PRECIS1000 In-Network | PRECIS1000 Out-of-Network |
|---|---|---|---|---|
| **Annual Deductible** (Per Person / Per Family) | $500 / $1,000 | $1000 / $3,000 | $1,000 / $3,000 | $2,000 / $6,000 |
| **Annual Out-of-Pocket Maximum** (Per Person / Per Family) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum | $1,000 / $3,000 | $2,000 / $6,000 | $2,000 / $6,000 | $4,000 / $12,000 |
| **Preventive Services** (Adults, Women, Children) | 0% | 30%* | 0% | 40%* |
| **Physician Office Visits** (Including Specialists) | $10 Copay | 30%* | $35 Copay | 40%* |
| **Urgent Care Visits** | $20 Copay | 30%* | $75 Copay | 40%* |
| **Inpatient Room & Care** (Semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting)) | $100 Copay** (Per day, up to 3 days) | | $150 Copay** (Per day, up to 3 days) | |
| **Outpatient / Ambulatory Surgery Services & Birthing Centers** | $100 Copay** | | $150 Copay** | |
| **Emergency Room Services** | $100 Copay** | | $150 Copay** | |
| **Laboratory Services** (Non-Hospital Based) | 0% | 30%* | 0% | 40%* |
| **Laboratory Services** (Hospital Based) | 10%*,*** | | 20%*,*** | |
| **CT/MRI/MRA/PET Scan** (Non-Hospital Based) | 10%**** | 30%* | 20%**** | 40%* |
| **CT/MRI/MRA/PET Scan** (Hospital Based) | 10%*,*** | | 20%*,*** | |
| **Ground Ambulance and Air Ambulance** | $150 Copay** | | $200 Copay** | |
| **Pharmacy Provisions** | | | | |
| **Annual Out-of-Pocket Maximum** (Per Person / Per Family) | $5,850 / $10,700 | | $4,850 / $7,700 | |
| **Preventive Prescription Drugs** (Pharmacy Retail - up to a 31 Day supply) | Generic Only - $0 | | Generic Only - $0 | |
| **Non-Preventive Prescription Drugs** (Pharmacy Retail - up to a 31 Day supply) | $10 / $20 / $35 | | $10 / $20 / $35 | |
| **Specialty Drugs** | 20% Coinsurance, up to $150 Copayment Benefit Maximum | | 20% | |

**In-Network**: For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate for Participating Providers.

**Out-of-Network**: For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Reasonable and Allowed Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Reasonable and Allowed Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.

* Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
** Plus amounts that exceed the Reasonable and Allowed Charges (waived if admitted to Inpatient status)
*** Participating Deductible applies
**** After Annual Deductible

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| Medical Provisions | PRECIS2000 In-Network | PRECIS2000 Out-of-Network | PRECIS3000 In-Network | PRECIS3000 Out-of-Network |
|---|---|---|---|---|
| **Annual Deductible** (Per Person / Per Family) | $2,000 / $6,000 | $4,000 / $12,000 | $3,000 / $6,000 | $6,000 / $12,000 |
| **Annual Out-of-Pocket Maximum** (Per Person / Per Family) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum | $4,000 / $12,000 | $8,000 / $24,000 | $6,000 / $12,000 | $12,000 / $24,000 |
| **Preventive Services** (Adults, Women, Children) | 0% | 50%* | 0% | 50%* |
| **Physician Office Visits** (Including Specialists) | $25 Copay | 50%* | $25 Copay | 50%* |
| **Urgent Care Visits** | $35 Copay | 50%* | $50 Copay | 50%* |
| **Inpatient Room & Care** (Semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting)) | $200 Copay** (Per day, up to 3 days) | | $250 Copay** (Per day, up to 3 days) | |
| **Outpatient / Ambulatory Surgery Services & Birthing Centers** | $200 Copay** | | $250 Copay** | |
| **Emergency Room Services** | $200 Copay** | | $250 Copay** | |
| **Laboratory Services** (Non-Hospital Based) | 0% | 50%* | 30%**** | 50%* |
| **Laboratory Services** (Hospital Based) | 20%*,*** | | 40%*,*** | |
| **CT/MRI/MRA/PET Scan** (Non-Hospital Based) | 20%**** | 50%* | 30%**** | 50%* |
| **CT/MRI/MRA/PET Scan** (Hospital Based) | 20%*,*** | | 40%*,*** | |
| **Ground Ambulance and Air Ambulance** | $250 Copay** | | 40%*,*** | |
| **Pharmacy Provisions** | | | | |
| **Annual Out-of-Pocket Maximum** (Per Person / Per Family) | $1,700 / $1,700 | | $3,000 / $6,000 Combined with the Medical Annual Out-of-Pocket Maximum | |
| **Preventive Prescription Drugs** (Pharmacy Retail - up to a 31 Day supply) | Generic Only - $0 | | Generic Only - $0 | |
| **Non-Preventive Prescription Drugs** (Pharmacy Retail - up to a 31 Day supply) | $25 / $40 / $55 | | $15 / $50 / $75 | |
| **Specialty Drugs** | 20% | | 20% | |

**In-Network**: For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate for Participating Providers.

**Out-of-Network**: For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Reasonable and Allowed Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Reasonable and Allowed Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.

* Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
** Plus amounts that exceed the Reasonable and Allowed Charges (waived if admitted to Inpatient status)
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**** After Annual Deductible

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| Medical Provisions | HDHP3000 In-Network | HDHP3000 Out-of-Network | HDHP5000 In-Network | HDHP5000 Out-of-Network |
|---|---|---|---|---|
| **Annual Deductible** (Per Person / Per Family) | $3,000 / $6,000 | $6,000 / $12,000 | $5,000 / $10,000 | $10,000 / $20,000 |
| **Annual Out-of-Pocket Maximum** (Per Person / Per Family) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum | $3,000 / $6,000 | $8,000 / $16,000 | $5,000 / $12,000 | $13,200 / $26,400 |
| **Preventive Services** (Adults, Women, Children) | 0% | 50%* | 0% | 50%* |
| **Physician Office Visits** (Including Specialists) | 0% | 50%* | 0%*,*** | 50%* |
| **Urgent Care Visits** | 0% | 50%* | 0%*,*** | 50%* |
| **Inpatient Room & Care** (Semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting)) | 0%*,*** | | 0%*,*** | |
| **Outpatient / Ambulatory Surgery Services & Birthing Centers** | 0%*,*** | | 0%*,*** | |
| **Emergency Room Services** | 0%*,*** | | 0%*,*** | |
| **Laboratory Services** (Non-Hospital Based) | 0%**** | 50%* | 0%**** | 50%* |
| **Laboratory Services** (Hospital Based) | 0%*,*** | | 0%*,*** | |
| **CT/MRI/MRA/PET Scan** (Non-Hospital Based) | 0%**** | 50%* | 0%**** | 50%* |
| **CT/MRI/MRA/PET Scan** (Hospital Based) | 0%*,*** | | 0%*,*** | |
| **Ground Ambulance and Air Ambulance** | 0%*,*** | | 0%*,*** | |
| **Pharmacy Provisions** | | | | |
| **Annual Out-of-Pocket Maximum** (Per Person / Per Family) | $3,000 / $6,000 Combined with the Medical Annual Out-of-Pocket Maximum | | $5,000 / $10,000 Combined with the Medical Annual Out-of-Pocket Maximum | |
| **Preventive Prescription Drugs** (Pharmacy Retail - up to a 31 Day supply) | Generic Only - $0 | | Generic Only - $0 | |
| **Non-Preventive Prescription Drugs** (Pharmacy Retail - up to a 31 Day supply) | $0**** | | $0**** | |
| **Specialty Drugs** | 20% | | 20% | |

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**Out-of-Network**: For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Reasonable and Allowed Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Reasonable and Allowed Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.

* Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
** Plus amounts that exceed the Reasonable and Allowed Charges (waived if admitted to Inpatient status)
*** Participating Deductible applies
**** After Annual Deductible

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| Medical Provisions | PRECIS5000 In-Network | PRECIS5000 Out-of-Network | HDHP6500 In-Network | HDHP6500 Out-of-Network |
|---|---|---|---|---|
| **Annual Deductible** (Per Person / Per Family) | $5,000 / $10,000 | $10,000 / $20,000 | $5,000 / $10,000 | $10,000 / $20,000 |
| **Annual Out-of-Pocket Maximum** (Per Person / Per Family) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum | $5,000 / $10,000 | $13,200 / $26,400 | $6,500 / $13,000 | $13,00 / $26,000 |
| **Preventive Services** (Adults, Women, Children) | 0% | 50%* | No Copay | 50%* |
| **Physician Office Visits** (Including Specialists) | $25 Copay | 50%* | 30% Coinsurance **** | 50%* |
| **Urgent Care Visits** | $50 Copay | 50%* | 30% Coinsurance **** | 50%* |
| **Inpatient Room & Care** (Semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting)) | $250 Copay** (Per day, up to 3 days) | | 30% Coinsurance**, *** (After Annual Deductible) | |
| **Outpatient / Ambulatory Surgery Services & Birthing Centers** | $250 Copay** | | 30% Coinsurance**, *** (After Annual Deductible) | |
| **Emergency Room Services** | $250 Copay** | | 30% Coinsurance**, *** (After Annual Deductible) | |
| **Laboratory Services** (Non-Hospital Based) | 20%**** | 50%* | 30%**** | 50%*, **** |
| **Laboratory Services** (Hospital Based) | 20%*,*** | | 30% Coinsurance**, *** (After Annual Deductible) | |
| **CT/MRI/MRA/PET Scan** (Non-Hospital Based) | 20%**** | 50%* | 30%**** | 50%*, **** |
| **CT/MRI/MRA/PET Scan** (Hospital Based) | 20%*,*** | | 30% Coinsurance**, *** (After Annual Deductible) | |
| **Ground Ambulance and Air Ambulance** | 20%*,*** | | Please see Summary of Benefits | |
| **Pharmacy Provisions** | | | | |
| **Annual Out-of-Pocket Maximum** (Per Person / Per Family) | $5,000 / $10,000 Combined with the Medical Annual Out-of-Pocket Maximum | | Combined with the Medical Annual Out-of-Pocket Maximum | |
| **Preventive Prescription Drugs** (Pharmacy Retail - up to a 31 Day supply) | Generic Only - $0 | | Generic Only - $0 | |
| **Non-Preventive Prescription Drugs** (Pharmacy Retail - up to a 31 Day supply) | $15 / $50 / $75 | | Generic: 0%**** Preferred & Non-Preferred Brand: 30% Coinsurance**** | |
| **Specialty Drugs** | 20% | | 30% (After Annual Deductible) | |

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** Plus amounts that exceed the Reasonable and Allowed Charges (waived if admitted to Inpatient status)
*** Participating Deductible applies
**** After Annual Deductible

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