

Non-Grandfathered

Plan Design For: Dove Technologies
 Plan Name: Buy Up Plan
 Effective Date: September 1, 2022

The following Benefit Summary is only a brief, non-legal outline of the benefits offered.

| BENEFITS | IN-NETWORK | OUT-OF-NETWORK |
|--|--|---------------------------------------|
| MEDICAL AND SURGICAL BENEFITS | | |
| Deductible (Embedded*) | \$1,250 Individual / \$2,500 Family | \$8,000 Individual / \$16,000 Family |
| Coinsurance (Shown as percentages below) | \$5,500 Individual / \$11,000 Family | \$10,000 Individual / \$20,000 Family |
| Standard Out-of-Pocket Includes Deductible and Coinsurance | \$6,750 Individual / \$13,500 Family | \$18,000 Individual / \$36,000 Family |
| Standard Out-of-Pocket: Allowable charges for Coinsurance are paid at 100% after the Standard Out-of-Pocket is met. | | |
| In-Network Maximum Out-of-Pocket Includes Deductible, Co-pays and Coinsurance | \$7,900 Individual / \$15,800 Family | |
| Physician Services in the Office Excluding Obstetrical Delivery, Dialysis Treatment, Chemotherapy, Radiation and Second Surgical Opinion <i>Includes allergy injections</i> | \$35 Primary Care Co-pay, then 100% \$60 Specialist Co-pay, then 100% Primary Care = General, Family Doctor, Pediatrician, Internist, OB/GYN | Deductible, 50% |
| Blue CareOnDemand SM | \$25 Co-pay, then 100% | Not Covered |
| Other Physician Services Inpatient / Outpatient hospital, anesthesia services, radiology, chemotherapy, dialysis, pathology, obstetrical delivery, initial newborn pediatric exam and all other outpatient / office services | Deductible, 80% | Deductible, 50% |
| Wellness Benefits – Based on the Health Care Reform Guidelines refer to www.healthcare.gov | 100% | Not Covered |
| Sustained Health Services (\$300 annual maximum) | \$35 Co-pay, then 100% | Not Covered |
| Annual Physicals and Sustained Health Services are only covered at a Primary Care Provider. | | |
| Inpatient Facility Charges | \$350 Co-pay, then 80% | \$500 Co-pay, then 50% |
| Skilled Nursing Facility Charges (60 days per year) | \$350 Co-pay, then 80% | \$500 Co-pay, then 50% |
| Outpatient Facility Charges | Deductible, 80% | Deductible, 50% |
| Other Services Physical / Occupational Therapy (30 combined visits) Home Healthcare Hospice | Deductible, 80% | Deductible, 50% |
| Chiropractic Benefits (\$500 annual maximum) | Deductible, 50% | Deductible, 50% |
| Ambulance | Deductible, 80% | In-Network Deductible, 80% |
| Urgent Care | \$60 Co-pay, then 100% | Deductible, 50% |
| Emergency Room Facility Charges ** | Deductible, 80% | Deductible, 80% |
| Emergency Room Professional Charges ** | Deductible, 80% | Deductible, 80% |
| **Out-of-Network Emergency Facility and Professional charges are subject to In-Network Coinsurance and/or Co-pay and Out-of-Network Benefit Year Deductible and Out-of-Pocket. | | |
| MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS | | |
| Inpatient Facility Charges | \$350 Co-pay, then 80% | \$500 Co-pay, then 50% |
| Inpatient Professional Charges | Deductible, 80% | Deductible, 50% |
| Outpatient Facility Charges | Deductible, 80% | Deductible, 50% |
| Outpatient Professional Charges | Deductible, 80% | Deductible, 50% |
| Emergency Room Facility Charges | Deductible, 80% | In-Network Deductible, 80% |
| Emergency Room Professional Charges | Deductible, 80% | In-Network Deductible, 80% |
| Physician Services in the Office | \$35 Co-pay, then 100% | Deductible, 50% |
| PHARMACY BENEFITS | | |
| Prescriptions Mandatory Generic (Includes diabetic supplies and oral contraceptives) Retail (31 day supply)*** Mail Order (90 day supply) | \$15 (Generic) / \$40 (Preferred) / \$70 (Non-Preferred) \$25 (Generic) / \$90 (Preferred) / \$175 (Non-Preferred) | 50% after Co-pay Not Covered |
| ***Member may purchase a 90 day Supply of a Generic Prescription, however 3 Retail Generic co-pays will apply at the time of purchase. | | |
| Specialty Drug – Optum Specialty Pharmacy Only 1-877-259-9428 for inquiries regarding this benefit | \$125 Co-pay per 31 day supply | Not Covered |
| BENEFIT MAXIMUMS | | |
| Annual / Lifetime Maximum | Unlimited | |

*Embedded Deductible: An individual deductible “embedded” within the family deductible. Before the insurance benefits begin the individual must meet the embedded individual deductible amount, which is equal to the single coverage deductible.

IMPORTANT NUMBERS

Customer Service: 1-800-760-9290

Pre-Authorization: 1-800-327-3238

Pre-Authorization for MRI, MRA, PET, CT & CAT scans: 1-866-500-7664

Pre-Authorization for Mental Health and Substance Abuse: 1-800-868-1032