

Non-Grandfathered

Plan Design For: Dove Print Solutions  
 Plan Name: Enhanced Plan  
 Effective Date: September 1, 2021

Signature	Date
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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		
<b>Deductible (Embedded*)</b>	\$1,250 Individual / \$2,500 Family	\$8,000 Individual / \$16,000 Family
<b>Coinsurance (Shown as percentages below)</b>	\$5,500 Individual / \$11,000 Family	\$10,000 Individual / \$20,000 Family
<b>Standard Out-of-Pocket</b> Includes Deductible and Coinsurance	\$6,750 Individual / \$13,500 Family	\$18,000 Individual / \$36,000 Family
<b>Standard Out-of-Pocket: Allowable charges for Coinsurance are paid at 100% after the Standard Out-of-Pocket is met.</b>		
<b>In-Network Maximum Out-of-Pocket</b> Includes Deductible, Co-pays and Coinsurance	\$7,900 Individual / \$15,800 Family	
<b>Physician Services in the Office</b> 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%
<b>Blue CareOnDemand<sup>SM</sup></b>	\$25 Co-pay, then 100%	Not Covered
<b>Other Physician Services</b> 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%
<b>Wellness Benefits</b> – Based on the Health Care Reform Guidelines refer to <a href="http://www.healthcare.gov">www.healthcare.gov</a>	100%	Not Covered
<b>Sustained Health Services</b> (\$300 annual maximum)	\$35 Co-pay, then 100%	Not Covered
<b>Annual Physicals and Sustained Health Services are only covered at a Primary Care Provider.</b>		
<b>Inpatient Facility Charges</b>	\$350 Co-pay, then 80%	\$500 Co-pay, then 50%
<b>Skilled Nursing Facility Charges</b> (60 days per year)	\$350 Co-pay, then 80%	\$500 Co-pay, then 50%
<b>Outpatient Facility Charges</b>	Deductible, 80%	Deductible, 50%
<b>Other Services</b> Physical / Occupational Therapy (30 combined visits) Home Healthcare Hospice	Deductible, 80%	Deductible, 50%
<b>Chiropractic Benefits</b> (\$500 annual maximum)	Deductible, 50%	Deductible, 50%
<b>Ambulance</b>	Deductible, 80%	In-Network Deductible, 80%
<b>Urgent Care</b>	\$60 Co-pay, then 100%	Deductible, 50%
<b>Emergency Room Facility Charges **</b>	Deductible, 80%	Deductible, 80%
<b>Emergency Room Professional Charges **</b>	Deductible, 80%	Deductible, 80%
<b>**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.</b>		
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
<b>Inpatient Facility Charges</b>	\$350 Co-pay, then 80%	\$500 Co-pay, then 50%
<b>Inpatient Professional Charges</b>	Deductible, 80%	Deductible, 50%
<b>Outpatient Facility Charges</b>	Deductible, 80%	Deductible, 50%
<b>Outpatient Professional Charges</b>	Deductible, 80%	Deductible, 50%
<b>Emergency Room Facility Charges</b>	Deductible, 80%	In-Network Deductible, 80%
<b>Emergency Room Professional Charges</b>	Deductible, 80%	In-Network Deductible, 80%
<b>Physician Services in the Office</b>	\$35 Co-pay, then 100%	Deductible, 50%
PHARMACY BENEFITS		
<b>Prescriptions Mandatory Generic</b> (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
<b>***Member may purchase a 90 day Supply of a Generic Prescription, however 3 Retail Generic co-pays will apply at the time of purchase.</b>		
<b>Specialty Drug – Optum Specialty Pharmacy Only</b> 1-877-259-9428 for inquiries regarding this benefit	\$125 Co-pay per 31 day supply	Not Covered
BENEFIT MAXIMUMS		
<b>Annual / Lifetime Maximum</b>	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

### SERVICES AND SUPPLIES THAT ARE NOT PAID FOR

Some services or supplies you receive may not be covered under this health coverage. Expenses for the following will not be paid:

- Any service or supply that is not medically necessary. However, if a service is determined to be not medically necessary because it was not rendered in the least costly setting, covered expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.
- Custodial care. This is care meant simply to help people who cannot take care of themselves.
- Cosmetic or re-constructive procedures, unless following a mastectomy.
- Investigational or experimental services.
- Any treatment for surgery for obesity, weight reduction, weight control or complications there from, reversal or re-constructive procedures resulting from such treatment.
- Services or supplies related to dysfunctional conditions of the muscles of mastication, malposition, or deformities of the jawbone, orthognathic deformities or TMJ (Temporomandibular Joint Disorder including, but not limited to, surgical treatment, appliances and orthodontia.)
- Treatment resulting from acts of war or military service.
- Services you are not charged for in VA hospitals or other kinds of hospitals or agencies.
- Any service or supply provided by a member of the patient's family or by the patient, including the dispensing of drugs. A member of the patient's family means spouse, parent, grandparent, brother, sister, child or spouse's parent.
- Services or supplies you received before you had coverage under this group contract or after you no longer have this coverage.
- Luxury or convenience items and travel expenses, whether or not recommended by a physician.
- Services or supplies payable by Medicare, workers compensation or any other government or private program.
- Private duty services by sitters or companions; private duty services by RNs and LPNs unless these services are part of an approved home health or hospice program.
- Reversals of tubal ligations or vasectomies.
- Prescription drugs bought at a doctor's office, skilled nursing home, hospital or any other place that is not a pharmacy licensed to dispense drugs in the state where it is operated.
- Any service or treatment for complications resulting from any non-covered procedures.
- Any service or supply rendered to a member for diagnosis or treatment of infertility.
- Any service or supply rendered to a member for the diagnosis or treatment to change gender or to improve or restore sexual function.
- Relationship counseling, including marriage counseling, for the treatment of pre-marital, marital or relationship dysfunction.
- Services and supplies related to routine foot care.
- Food supplements, even if the supplements are ordered or prescribed by a physician.
- Prescription drugs used for weight control, obesity, cosmetic purposes, hair growth or fertility.
- Any service or supply the member is not legally obligated to pay.
- Services for the removal of impacted teeth.
- Eyeglasses, contact lenses (except after cataract surgery), hearing aids and examination for the prescription or fitting thereof and any hospital or physician charges related to refractive care.
- Any medical social services, occupational, visual, speech, recreational, behavioral, educational or play therapy or biofeedback, except when part of a pre-authorized home health plan or hospice care program.
- Dental services, except for dental treatment up to 6 months after an accident.
- Services and supplies received for the treatment of any work-related accident or illness.
- Durable Medical Equipment at an out-of-network provider.
- Cranial Orthotics, except when deemed Medical Necessary.
- Hypnotism
- Pre-conception testing, pre-conception counseling or pre-conception genetic testing

### SERVICES AND SUPPLIES REQUIRING PREAUTHORIZATION

For Pre-Authorization: **Call 1-800-327-3238** for the following Services:

- Durable Medical Equipment over \$500, network only
- All inpatient hospital or skilled nursing facility admissions and in-patient psychiatric
- Home health care, hospice care or inpatient physical rehabilitation
- Outpatient psychiatric care, outpatient procedures for Chemotherapy or Radiation Therapy (one-time notification), Hysterectomy, Septoplasty, Sclerotherapy, all Cosmetic procedures, Investigational procedures performed in outpatient or office setting, all inpatient hospital or skilled nursing facility admissions.
- Services and supplies related to human organ and tissue transplants required to use Blue Distinction Centers of Excellence.
- Benefits will be reduced or declined if required pre-authorizations are not obtained.
- To receive pre-authorization for the following procedures: computed tomography (CT), computerized axial tomography (CAT), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA) or positron emission tomography (PET) scans. **Call 1-866-500-7664**
- Mental Health and Substance Abuse Services must be Pre-Authorized by CBA prior to services being rendered. **Call 1-800-868-1032**

### NOTICE OF OUR PRIVACY POLICIES AND PRACTICES

This Notice has been prepared to inform you of our practices related to information we collect about you. When necessary to provide our products and services to you, we may disclose any of the information we collect, as described below, (a) to companies that provide services on our behalf and (b) to affiliated and nonaffiliated third parties (such as health care providers who furnish treatment to you or other insurers to coordinate benefits). Otherwise, we do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

If you are a plan sponsor or group policyholder, this Privacy Notice describes our practices for safeguarding nonpublic personal financial information that we collect about participants and beneficiaries of your employee benefit plan(s).

**Information we collect and maintain:** We collect information about you from the following sources:

- Information we receive from you on applications or on other forms
- Information we obtain from your transactions with us, our affiliates, or others
- Information we receive from consumer-reporting agencies

**How we protect information:** We restrict access to nonpublic personal information about you to our employees who need to know the information to provide our products and services to you and as permitted by law. We maintain physical, electronic and procedural safeguards that comply with applicable legal requirements to guard your nonpublic personal financial information. We have installed usernames, passwords and other safety features on our Web applications to help ensure that the information about you that we collect and maintain remains safe and secure.

**Changes to this Notice:** We may amend our privacy policies and practices at any time, and we will inform you of any material changes as required by law.

**YOU DO NOT NEED TO DO ANYTHING IN RESPONSE TO THIS NOTICE.  
THIS NOTICE IS MERELY TO INFORM YOU ABOUT OUR  
PRIVACY POLICIES AND PRACTICES**

(06/2021)

