West Herr Automotive Group

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$1,600	$1,600	
Deductible - Family	$3,200	$3,200	
Coinsurance	0%	30%	
Annual Out of Pocket Maximum - Single	$5,000	$10,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$10,000	$20,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Per Person Cap	$6,650	$20,000	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Cost Share - Specialist	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	$0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$250 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	$250 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Substance Use Detoxification	$250 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$250 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	45 Days per contract year Limits are combined INN and OON.
Physical Rehabilitation	$250 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	60 Days per contract year Limits are combined INN and OON.
Maternity Care	$250 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - $0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - $0 Copayment Subject to Deductible	0% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$75 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	$0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Radiation Therapy	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Chemotherapy	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	$0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	$25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	$0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Home Infusion Therapy	$0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	$0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - $25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - $0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - $0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	30% Coinsurance Subject to Deductible	$0 Kids Copay applies to PCP and Specialist
Maternity Care	PCP/Specialist - $0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - $0 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	30% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
TeleMedicine Program	PCP/Specialist - $0 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - $25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	30% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - $0 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Immunizations	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - $25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 0% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 0% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$50 Copayment Subject to Deductible	$50 Copayment Subject to Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$50 Copayment Subject to Deductible	$50 Copayment Subject to Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$35 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	0% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	1 Pair per plan year
Adult Eye Exams - Routine	$25 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Covered	Covered	$60 Reimbursement per plan year

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$7/$50/$75 Integrated Rx

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.