



**NEW WEST  
HEALTH SERVICES**

# Innovations \$1,500 / \$3,000 • 60/40 and 50/50 Coinsurance Group Plan

## OUTLINE OF COVERAGE AND SCHEDULE OF BENEFITS

This Group Plan utilizes the Group Member Certificate Benefits Booklet.

### Outline of Coverage

NEW WEST HEALTH SERVICES IS REFERRED TO BELOW AS "NWHHS."

#### GENERAL BENEFIT INFORMATION

Your benefits booklet, any applicable endorsements and the following schedule of benefits describe the benefits and coverage provided under this Innovations plan. Generally, your coverage includes benefits for emergency care, urgent care, provider office visits, hospital care (inpatient and outpatient), durable medical equipment, prosthetics, orthotics, therapies, preventive, screening and diagnostic medical testing.

You are responsible for paying:

- Deductibles
- In-Network Coinsurance/Copayments
- Out-of-Network Coinsurance
- Expenses up to the maximum out-of-pocket amount
- Amounts that exceed benefit limitations, including the lifetime benefit maximum
- Costs for non-covered services
- Amounts that exceed NWHHS' allowed charges for non-participating providers

#### BENEFIT DIFFERENTIALS WHEN USING NON-PARTICIPATING PROVIDERS

**It is always to your benefit to use a participating provider. Benefits for out-of-network services always will be lower than benefits for in-network services.** The allowed charge for a health care service provided by a non-participating provider is 10% less than the allowed charge for the same health care service when provided by a participating provider. In addition, the coinsurance rate you pay is higher for health care services received from non-participating providers than the coinsurance rate you pay for health care services received from participating providers. Also, a provider's billed charge for a given health care service may be significantly greater than the allowed charge for that service. You are not responsible for paying this difference if you use a participating provider. However, you may be required to pay this difference if you use a non-participating provider.

This Group Plan utilizes the **New West Provider Network**.

#### PREMIUM DETERMINATION AND COSTS

Small group premiums are developed based upon our entire small group population (i.e., pooled with the rest of NWHHS' small group business for rating purposes). Certain characteristics of the group are factored into the rating process, such as demographics, geographic factors, and risk characteristics. Large group premiums are generally developed based upon a combination of claims/utilization, demographics, geographic factors, industry, risk, etc. They may be pooled with other groups of similar size.

The premium trend during the preceding 5 years, to the extent such data is available, reflects that premiums have increased by an average of about 11% per year.

## Schedule of Benefits

DEDUCTIBLE AND COINSURANCE APPLY TO ALL COVERED SERVICES UNLESS SPECIFICALLY STATED OTHERWISE IN THIS SCHEDULE OF BENEFITS, ENDORSEMENTS OR THE BENEFITS BOOKLET.

MEMBER PAYS	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
<p><b>DEDUCTIBLE</b> Per member per contract year. In-network and out-of-network deductibles are separate and never combined.</p> <p><b>COINSURANCE</b> Applicable after you pay the deductible for all covered services subject to coinsurance.</p> <p><b>OUT-OF-POCKET MAXIMUM</b> Per member. In-network and out-of-network out-of-pocket maximums are separate and are never combined. Only deductibles and coinsurance apply to out-of-pocket maximums. <i>Durable Medical Equipment, Orthotics and Prosthetics health care services do not apply to the out-of-pocket maximum.</i></p> <p><b>WELL CHILD CARE (BIRTH THROUGH 7 YEARS OF AGE)</b> Includes certain preventive medical testing and immunizations. For current recommended schedule, please contact Customer Service at 800-290-3657. Deductible is waived through age 7 for in- and out-of-network services.</p>	<p>\$1,500</p> <p>40%</p> <p>\$2,500</p> <p>Member Pays \$20 Office Visit Copay</p>	<p>\$3,000</p> <p>50%</p> <p>\$5,000</p> <p>50%</p>
NWHS PAYS	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
<p><b>COINSURANCE</b> Applicable after you pay the deductible for all covered services subject to coinsurance.</p> <p><b>LIFETIME BENEFIT MAXIMUM</b> Per member. For in-network and out-of-network combined.</p> <p><b>FIRST \$500 OFFICE VISITS PER CONTRACT YEAR</b> Each contract year, the first \$500 of allowed charges for office visits with a provider for primary, specialty, or urgent care, whether in- or out-of-network, do not apply to deductible, coinsurance or copayments. Deductible, copayments, and coinsurance will apply as applicable to any in-network or out-of-network office visits in excess of \$500. This office visit copayment benefit does not include any procedures and/or screening and/or diagnostic medical testing performed at the time of the office visit. Mental health treatment and care received in an emergency room are not covered under this benefit, and are always subject to deductible and coinsurance (see page 3 under <b>Mental Illness Health Care Services</b>.)</p> <p><b>VOLUNTARY STERILIZATION</b> For the first \$300 of allowed charges for covered services for vasectomies, tubal ligations and other forms of permanent sterilization; the rest of the allowed charges will be subject to deductible and coinsurance. This benefit is payable only once per lifetime.</p> <p><b>ACCIDENT BENEFIT</b> For the first \$600 of allowed charges for accident-related health care services per contract year (in-network and out-of-network combined). Deductible and/or coinsurance apply to any additional accident-related health care services. An accident report is required to receive this benefit.</p> <p><b>DIABETIC OUTPATIENT SELF-MANAGEMENT TRAINING &amp; EDUCATION</b> For the first \$250 of allowed charges for covered services per contract year (in-network and out-of-network combined). No benefits will be paid for these health care services once the \$250 benefit has been paid.</p>	<p>60%</p> <p>\$2,000,000</p> <p>100% of the first \$500 in allowed charges for office visits is paid by NWHS.</p> <p>NWHS Pays 100% Member Pays 0%</p> <p>NWHS Pays 100% Member Pays 0%</p> <p>NWHS Pays 100% Member Pays 0%</p>	<p>50%</p> <p>100% of the first \$500 in allowed charges for office visits is paid by NWHS.</p> <p>NWHS Pays 100% Member Pays 0%</p> <p>NWHS Pays 100% Member Pays 0%</p> <p>NWHS Pays 100% Member Pays 0%</p>

<b>PREVENTIVE CARE &amp; SCREENING SERVICES - DEDUCTIBLE IS WAIVED FOR IN-NETWORK AND OUT-OF-NETWORK SERVICES</b>	<b>IN-NETWORK SERVICES</b>	<b>OUT-OF-NETWORK SERVICES</b>
<b>ROUTINE NEWBORN EXAM</b> Generally performed before discharge from hospital following birth.	NWHS Pays 100% Member Pays 0%	NWHS Pays 100% Member Pays 0%
<b>AGE 8 TO ADULT</b> Includes certain preventive medical testing and immunizations based on age-appropriate recommendations and many are limited to one per contract year. For current recommended schedule, please contact Customer Service at 800-290-3657.	NWHS Pays 60% Member Pays 40%	NWHS Pays 50% Member Pays 50%
<b>ROUTINE IMMUNIZATIONS</b> Birth through age 7 and age 8 to adult. Child and adult (flu, Gardasil, etc.)	NWHS Pays 100% Member Pays 0%	NWHS Pays 100% Member Pays 0%
<b>BREAST CANCER SCREENING / MAMMOGRAPHY*</b> For baseline or diagnostic mammogram. <i>*The percent of allowed charges includes a minimum benefit payable of \$70, or the actual charge if less, as required by State law.</i>	NWHS Pays 100% Member Pays 0%	NWHS Pays 100% Member Pays 0%
<b>CERVICAL CANCER SCREENING</b>	NWHS Pays 100% Member Pays 0%	NWHS Pays 100% Member Pays 0%
<b>COLORECTAL CANCER SCREENING</b> Colonoscopy (every 10 years), or Barium Enema (every 5 years), or Sigmoidoscopy (every 5 years), and/or Fecal Occult Blood Testing (FOBT) annually <b>up to an annual maximum of \$1,300.</b>	NWHS Pays 100% Member Pays 0%	NWHS Pays 100% Member Pays 0%
<b>PROSTATE CANCER SCREENING</b> Rectal examination and Prostate Specific Antigen (PSA) testing.	NWHS Pays 100% Member Pays 0%	NWHS Pays 100% Member Pays 0%
<b>CHOLESTEROL AND LIPID DISORDER SCREENING</b>	NWHS Pays 100% Member Pays 0%	NWHS Pays 100% Member Pays 0%

<b>ANNUAL BENEFIT MAXIMUMS</b>	APPLY TO IN-NETWORK AND OUT-OF-NETWORK SERVICES COMBINED ON A CONTRACT YEAR BASIS, UNLESS OTHERWISE NOTED BELOW
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#### **ALCOHOL AND DRUG ADDICTION HEALTH CARE SERVICES**

- \$6,000 annual benefit maximum for inpatient and outpatient covered services combined. After reaching \$12,000 lifetime maximum in allowed charges for inpatient services, \$2,000 annual benefit maximum for inpatient and outpatient covered services combined (does not apply to inpatient detoxification treatment).

#### **CATARACT SURGERY-RELATED EYEGLASS LENSES & CONTACTS**

- One pair of eyeglass lenses or contacts, up to a \$250 benefit maximum per surgery.

#### **CHIROPRACTIC SERVICES**

- \$500 annual benefit maximum (including x-rays).

#### **DURABLE MEDICAL EQUIPMENT**

- \$5,000 annual benefit maximum combined with Orthotics. (Not applicable to diabetic insulin pumps.)

#### **HOME HEALTH CARE SERVICES**

- 60 days annual maximum benefit.

#### **MENTAL ILLNESS HEALTH CARE SERVICES**

- Inpatient: 21 inpatient days or 42 partial inpatient days annual benefit maximum. Outpatient: \$2,000 annual benefit maximum. Annual benefit maximums do not apply to health care services to treat severe mental illness.

#### **ORTHOTICS**

- \$5,000 annual benefit maximum combined with Durable Medical Equipment.

#### **OUTPATIENT CARDIAC REHABILITATION & PULMONARY REHABILITATION THERAPY**

- 15 visits combined annual benefit maximum.

#### **OUTPATIENT PHYSICAL THERAPY, SPEECH THERAPY & OCCUPATIONAL THERAPY**

- 30 visits combined annual benefit maximum.

#### **PROSTHETIC DEVICES**

- \$3,000 annual benefit maximum. (Not applicable to breast prostheses following a mastectomy.)

#### **SKILLED NURSING FACILITY**

- 60 days annual benefit maximum.

#### **SLEEP APNEA**

- \$500 annual benefit maximum for oral device and related health care services.

#### **TRANSPLANTS**

- \$500,000 lifetime benefit maximum\*. Must be at a facility designated by NWHHS as a transplant center of excellence.

\*Transplant-related travel expenses: \$5,000 benefit maximum per transplant. Copayments, deductibles and/or coinsurance do not apply to transplant-related travel. \$10,000 benefit maximum per transplant for surgery, storage and transportation of the human organ used in the transplant.

#### **OTHER LIMITATIONS**

#### **OUT-OF-NETWORK, NON-EMERGENCY, INPATIENT HOSPITAL HEALTH CARE SERVICES**

- \$4,000 daily limit on allowed charges for out-of-network, non-emergency, inpatient hospital health care services.

#### **GENERAL EXCLUSIONS AND LIMITATIONS**

REFER TO "GENERAL EXCLUSIONS AND LIMITS" IN YOUR BENEFITS BOOKLET. ALSO SEE THE BENEFITS BOOKLET AND ANY APPLICABLE ENDORSEMENTS FOR A LISTING OF COVERED SERVICES, EXCLUSIONS, AND LIMITATIONS.

**WANT MORE  
INFORMATION?**

If you have any questions about our health care programs,  
please contact Customer Service at:

**1-800-290-3657**

**[www.newwesthealth.com](http://www.newwesthealth.com)**



## Prescription Drug Endorsement - \$20 / \$40 / \$60

This outpatient prescription drug endorsement is part of the plan under which you are covered. The benefits described in this endorsement are subject to the terms and conditions of the plan, except as otherwise specifically provided in this endorsement. Your member identification card contains essential information about your prescription drug benefits.

**COPAYMENTS** The **copayment** is the amount for which you are responsible. The copayment must be paid to the pharmacy at the time the prescription is filled.

For generic drugs, the copayment is: \$20

For brand-name formulary drugs, the copayment is: \$40\*

For brand-name non-formulary drugs, the copayment is: \$60\*

\*Formulary drugs are brand-name drugs that New West has selected in each drug class based on their safety, efficacy, cost and clinical outcome. Any brand-name drug not included on the formulary listing is considered non-formulary.

You must use a generic drug when available. If a generic drug is available, you must use the generic drug to obtain full payment after you pay your copayment for the drug. **In the event that you choose to use a brand name drug when a generic drug is available, you must pay the formulary or non-formulary copayment, whichever applies, plus the difference between the cost of the generic drug and the cost of the brand name drug, or the actual price of the brand name drug, whichever is less.** However, if your provider requires that the prescription be dispensed as written for a brand name drug that has a generic equivalent, you will only be required to pay the copayment for the cost of the brand name drug.

Detailed medication coverage for New West's prescription drug plans is available on our website at [www.newwesthealth.com](http://www.newwesthealth.com) and an abbreviated listing of the specific medications that are covered is mailed to members annually in our prescribing guide. New West does offer coverage for most oral medications and many specialty medications. We do make frequent changes to our prescribing guide, so please refer to the most current coverage booklet at our website or contact Customer Service at 800-290-3657 if you would like more information about a specific drug.

### COVERED PRESCRIPTION DRUGS

- Legend drugs - drugs that require written prescriptions and are dispensed by a licensed pharmacist
- Prescription contraceptive medications and supplies
- Compounded medications of which one or more ingredients is a legend drug

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**PARTICIPATING  
NETWORK  
PHARMACY  
INFORMATION**

Included in your enrollment packet is a list of pharmacies in the New West participating retail pharmacy program. It is recommended that you fill your prescriptions at a participating pharmacy. Using a participating pharmacy allows you to take advantage of the discounted price New West has negotiated for, even when you are still meeting your deductible. If you use a non-participating pharmacy, you will be responsible for the cost of the copayment, if applicable, plus any difference between the medication's actual price and the allowed charge for the medication, which may result in higher than expected out-of-pocket expenses.

For details on how to request reimbursement for non-participating pharmacy claims or if you need assistance in identifying a participating pharmacy, please contact Customer Service at 800-290-3657. You may also visit our website for details and claim forms at [www.newwesthealth.com](http://www.newwesthealth.com).

**MAIL ORDER  
AND SPECIALTY  
MEDICATION  
SERVICES**

**Mail Order**

This pharmacy benefit entitles you to receive up to a 90-day or three-month supply of maintenance prescription medications through the mail. You will be responsible for two copayments instead of three (which is what you would pay for each 30-day supply at a local pharmacy) which makes this program financially beneficial to utilize. First time orders should be placed via fax or mail, and reorders can be made via the website at [www.caremark.com](http://www.caremark.com). Please call the Caremark phone number on your NWHS identification card or call New West Customer Service at 800-290-3657 for more details about how to use your mail order services.

**Specialty Medications**

In an effort to reduce prescription-related health care costs, New West has contracted with CVS/Caremark to allow for specially discounted rates on certain medications that are considered "specialty" medications. These can include medications that are injected, infused, require special handling, and/or are for certain medical conditions that require frequent monitoring. These medications are only available through New West's specialty medication program and cannot be purchased from a local pharmacy. Please contact New West Customer Service at 800-290-3657 for a current list of these medications as the list may change frequently.

**COORDINATION  
OF BENEFITS**

In the event that New West is determined to be the secondary payer, we will coordinate benefits with the primary prescription carrier. At the point of sale, the pharmacist will receive a message indicating there is another carrier that should be the primary payer. It is required that the member submit the primary carrier's prescription receipt or explanation of benefits to the New West pharmacy carrier so that proper reimbursement can be made.

You may contact Customer Service at 800-290-3657 for assistance or visit our website at [www.newwesthealth.com](http://www.newwesthealth.com). New West will coordinate benefits as outlined in your benefits booklet under COORDINATION OF BENEFITS.

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**PROGRAM LIMITATIONS,  
PRIOR AUTHORIZATION  
REQUIREMENTS AND  
EXCLUSION  
INFORMATION**

**Limitations**

- Benefits may be payable under this endorsement only while you are covered for prescription drug benefits.
- The drugs must be prescribed by a provider acting within the scope of his or her license.
- The prescription drug deductible and copayments do not apply to your health insurance plan's deductible or out-of-pocket maximum.
- You will pay the actual price of the prescription drug when it is less than the copayment amount.
- Benefits may be payable for outpatient injectables only when oral administration is not appropriate.
- Drugs or medicines for erectile dysfunction are limited to 6 doses per month.
- The following conditions and specific prescription drugs, and any generic equivalent, **must be authorized** or they will not be covered. This list is not all-inclusive and may be amended from time to time. Please call Customer Service at 800-290-3657 to determine if your medication requires authorization. Also see the AUTHORIZATION section in your benefits booklet.
  - AIDS/HIV medications (e.g., Truvada, Epzicom)
  - Anorexants, anorectics and diet aids
  - Antineoplastic medications (e.g., Xeloda, Temodar)
  - Biologic Response Modifier medications (e.g., Arava, Enbrel, Remicade, Xolair)
  - Hepatitis medications (e.g., Hepsera)
  - Certain hormone medications, limited to Sandostatin, growth hormone and osteoporosis medications (e.g., Forteo)
  - Immunomodulators (e.g., Kineret, Synagis)
  - Immunosuppressants (e.g., Amevive, Cellcept)
  - Pulmonary Antihypertensives (e.g., Remodulin, Revatio, Flolan)
  - Retinoid medications (e.g., Soriatane CK)
  - Topical Tretinoin medications for adults over age 35 (e.g., Retin-A)
- Conditions:
  - Unclassified/newly released medications
  - Vacation prescriptions (overrides for duplicate fills are limited to a bi-annual maximum)
  - Lost medications (overrides for lost or stolen medications are limited to a bi-annual maximum and are not available for narcotics)
  - Medications over \$1,000 per prescription
  - Newly released specialty medications

**Exclusions**

No coverage is available for:

- Medications filled at local or retail pharmacies for greater than a 34-day supply
- Medications filled through a mail order program for greater than a 90-day supply
- More than one purchase of a prescription drug during the dosage period recommended by the prescribing provider

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- Medications filled by either mail or specialty programs and supplied by non-contracted pharmacies
  - Prescription drugs received outside the United States, other than those received as part of emergency or urgent care
  - Drugs, injectables and/or supplies that are:
    - Not approved by the United States Food and Drug Administration (FDA)
    - Prescribed for a medical condition other than the medical condition(s) for which they were approved by the FDA
    - Dispensed in a quantity or amount in excess of that specified by the prescribing provider
  - Drugs or medicines for infertility treatment
  - Non-legend drugs
  - Anabolic steroids
  - Prescription drugs that stimulate hair growth (e.g., Minoxidil)
  - Vitamins, minerals, nutritional supplements, and homeopathic and herbal remedies
  - Over-the-counter drugs and supplies, including, but not limited to, drugs that formerly were available only by prescription, but now are available over-the-counter, and any therapeutically equivalent drugs (whether or not they are available over-the-counter) that are in the same drug class as the drug that now is available over-the-counter.

SEE THE BENEFITS BOOKLET FOR ADDITIONAL EXCLUSIONS & LIMITATIONS.

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