



New West Select Health Savings Account (HSA) Eligible \$5,000 Deductible 100/0 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 "NWHS."

GENERAL BENEFIT INFORMATION

Your benefits booklet, any applicable endorsements and the following schedule of benefits describe the benefits and coverage provided under this New West Select 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:

- Deductible
- 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 NWHS' 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 will always 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. 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 NWHS' 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 APPLIES TO ALL COVERED SERVICES UNLESS SPECIFICALLY STATED OTHERWISE IN THIS SCHEDULE OF BENEFITS, ENDORSEMENTS OR THE BENEFITS BOOKLET.

MEMBER PAYS

Deductible:

- \$5,000 per member per contract year.
- \$10,000 per family per contract year.

Coinsurance:

- 0% of allowed charges after you pay the deductible for all covered services subject to coinsurance.

Out-of-Pocket Maximum:

- \$5,000 per member per contract year.
- \$10,000 per family per contract year.

Only deductible applies to the out-of-pocket maximum. Durable Medical Equipment, Orthotics and Prosthetics health care services do not apply to the out-of-pocket maximum.

NWHS PAYS

Coinsurance:

- 100% of allowed charges after you pay the deductible for all covered services.

Lifetime Benefit Maximum:

- \$2,000,000 per member.

Diabetic Self-Management Training and Education:

- 100% of the first \$250 of outpatient covered services per contract year. No benefits will be paid for these health care services once the \$250 benefit has been paid.

First Dollar Coverage Benefit:

- Deductible waived for the first \$500 of allowed charges each contract year for preventive and screening services as noted below.
 - Note: Excludes separately listed benefits on this Schedule of Benefits, such as breast cancer screening and mammography, colorectal cancer screening and well child care.

PREVENTIVE AND SCREENING SERVICES

Routine Newborn Exam:

- 100% of allowed charges. (Generally performed before discharge from the hospital following birth.) Deductible is waived.

Well Child (birth through 7 years of age):

- 100% of allowed charges for office visits (includes certain preventive medical testing and immunizations.) Deductible is waived through age 7. For current recommended schedule and list of current preventive services, please contact Customer Service at 800-290-3657.

Age 8 to Adult:

- 100% of allowed charges per office visit (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 and list of current preventive services, please contact Customer Service at 800-290-3657. Applies to First Dollar Coverage Benefit.

Routine Immunizations:

- 100% of allowed charges from birth through age 7 with deductible waived. Age 8 to adult, applies to First Dollar Coverage Benefit.
- Routine immunizations such as flu, Gardasil, etc., for children and adults.

Breast Cancer Screening and Mammography*:

- 100% of allowed charges for a baseline or screening mammogram. Deductible is waived.

*Your Breast Cancer Screening/Mammography benefit includes, but is not limited to, the \$70 State required mandated benefit and is payable at 100% of allowed charges by NWHHS.

Cervical Cancer Screening:

- 100% of allowed charges. Applies to First Dollar Coverage Benefit.

Colorectal Cancer Screening:

- **\$1,300 annual benefit maximum.** Colonoscopy (every 10 years), or Barium Enema (every 5 years), or Sigmoidoscopy (every 5 years), and/or Fecal Occult Blood Testing (FOBT) annually. Deductible is waived.

Prostate Cancer Screening:

- 100% of allowed charges. Rectal examination and Prostate Specific Antigen (PSA) testing. Applies to First Dollar Coverage Benefit.

Cholesterol and Lipid Disorder Screening:

- 100% of allowed charges. Applies to First Dollar Coverage Benefit.

**ANNUAL BENEFIT
MAXIMUMS**

APPLY ON A CONTRACT YEAR BASIS, UNLESS OTHERWISE NOTED BELOW.

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 maximum benefit.

Outpatient Physical Therapy, Speech Therapy & Occupational Therapy:

- 30 visits combined annual maximum benefit.

Prosthetic Devices:

- \$3,000 annual benefit maximum. (Not applicable to breast implants 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 NWHS 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.

**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



Integrated Prescription Drug Endorsement - Group

This mandatory 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.

This endorsement provides you with benefits for outpatient prescription drugs, injectables and/or supplies (collectively referred to below as prescription drugs) that qualify as covered services under the plan. Under this endorsement, you can purchase prescription drugs at a discount, when applicable, and then submit claims to New West Health Services (New West) that will apply to your deductible. Once your deductible is met, you will no longer need to submit claims to New West and your prescription benefits will be covered according to the terms and conditions of your plan.

PARTICIPATING NETWORK PHARMACY INFORMATION

This endorsement entitles you to receive discounts on some or all of the prescription drugs you need through the New West participating retail or mail order pharmacy programs. By showing your member identification card to a participating pharmacy, the pharmacy will determine if a discount is available for your prescription drugs. **Your eligibility for a discount does not mean that the prescription drugs you buy are covered services under this endorsement or otherwise under the plan. Discounts may be available for prescription drugs that are not covered services.**

Included in your enrollment packet is a list of pharmacies in the New West participating retail pharmacy program. If you need assistance in identifying a participating pharmacy, please contact Customer Service at 800-290-3657 or visit our website at www.newwesthealth.com.

Discounts are available for the following types of 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.
- Insulin and other diabetic supplies, including disposable insulin needles, syringes, lancets, and blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest Tablets, Diastix Strips, and Tes-Tape).

To receive any available discount, you must fill your prescriptions at a participating pharmacy or use the prescription mail order benefit available through New West Health Services. If you use a non-participating pharmacy, including a pharmacy outside the United States, you are not eligible for the discount and will need to submit receipts for benefits, as applicable. Any medications and drugs received outside the United States are not covered, except for those received as part of emergency or urgent care, regardless of whether the policy has a drug prescription endorsement.

**OBTAINING
PRESCRIPTION DRUG
BENEFITS**

After you have received your prescription drugs, you must submit a claim to New West to obtain any benefits payable for those prescription drugs under this endorsement. See CLAIMS in the benefits booklet for the information you need to include in your claim and the time limits for submitting your claim. **The pharmacy will not submit claims for you until you have satisfied your combined deductible. Once you have met your integrated deductible, your prescription drugs will be paid at 100% at a participating pharmacy.**

Claims should be sent to: NWHS Claims, P. O. Box 548, Kalispell, MT 59903-0548

Once New West receives your claim for benefits for the prescription drugs, the claim will be processed in accordance with the terms and conditions of the plan, including, but not limited to, determining the allowed charges for the prescription drugs and applying deductible and/or coinsurance, as appropriate.

**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)

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- 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
- 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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