IHP | Ultimate

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Individual	$0	$500
Family	$0	$1,000

Out of Pocket Information

Out of Pocket Maximum	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Individual	$2,000	Unlimited
Family	$13,200	Unlimited

Schedule of Benefits

The following table represents the medical services currently covered under the IHP Ultimate Plan, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

Plan Provisions	Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
		Member Pays	
PHYSICIAN SERVICES			
Primary Care Office Visit	No	$20 Copay	After Deductible, 40% Coinsurance
Specialist Office Visit (Includes Mental and Behavioral Health)	No	$40 Copay	After Deductible, 40% Coinsurance
Other Physicians Services performed in the office[2]	Yes[3]	$40 Copay	After Deductible, 40% Coinsurance
Urgent Care	No	$50 Copay	After Deductible, 40% Coinsurance
Telemedicine Services	No	$0 Copay	Not Applicable

[1] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.
[2]The plan will only reimburse buy and bill drugs up to the lessor of the allowed amount or network rate or the amount that the Third-Party Administrator or Pharmacy Benefits Manager could source the drug for.
[3]Prior authorization is required for any service or procedure over $1,000.

IHP | Ultimate

Plan Provisions		Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers\ (Out of Network)
			Member Pays	
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services section)	**(Non-Hospital Based)**	No	$0 Copay	$0 Copay
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
HOSPITAL/FACILITY SERVICES (Subject to RBP)				
Inpatient Hospitalization		Yes	$400 Copay (After copay, benefit subject to RBP)	
Inpatient Visits - Physician		No	Included in Inpatient Hospitalization Copay	
Inpatient Surgery – Physician Charges		Yes	Included in Inpatient Hospitalization Copay	
Outpatient Hospital or Free-Standing Facility Services and Surgery		Yes	$400 Copay (After copay, benefit subject to RBP)	
Anesthesia		No	Included in Inpatient Hospitalization or Outpatient Hospital or Free-Standing Facility Services and Surgery Copay	
Emergency Room Facilities and Covered Services		No	$400 Copay (After copay, benefit subject to RBP)	
OUTPATIENT DIAGNOSTIC SERVICES				
Laboratory Services	**(Non-Hospital Based)**	No	$50 Copay	After Deductible, 40% Coinsurance
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Radiology	**(Non-Hospital Based)**	No	$50 Copay	After Deductible, 40% Coinsurance
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
CT/MRI/MRA/PET Scan	**(Non-Hospital Based)**	Yes	$400 Copay (After copay, benefit subject to RBP)	
	(Hospital Based)	Yes		

IHP | Ultimate

Plan Provisions	Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
		Member Pays	
PREGNANCY BENEFITS			
Professional Services	No	$50 Copay	After Deductible, 40% Coinsurance
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)	Yes	$400 Copay (After copay, benefit subject to RBP)	
OTHER SERVICES			
Allergy Services (The copay applies to the administration of the allergy service and is separate from the copay for the office visit)	No	$40 Copay	$40 Copay
Chemotherapy/Radiation Therapy (Chemotherapy only includes infusion, not oral)	Yes	$400 Copay (After copay, benefit subject to RBP)	
Chiropractic Services (Limited to 10 visits per plan year)	No	$40 Copay	After Deductible, 40% Coinsurance
Colonoscopy (Diagnostic Purposes)	Yes	$400 Copay (After copay, benefit subject to RBP)	
Dialysis	Yes	$400 Copay (After copay, benefit subject to RBP)	
Durable Medical Equipment (Subject to limitations)	Yes	$400 Copay (After copay, benefit subject to RBP)	
Emergency Medical Transportation (Ground Service Only)	No	$400 Copay (After copay, benefit subject to RBP)	
Home Health Care (Limited to 20 visits per plan year)	Yes	$25 Copay	Not Covered 100% paid by Member
Hospice Care	Yes	$400 Copay (After copay, benefit subject to RBP)	
Rehabilitation/Habilitation Services (Combined limit of 20 visits per plan year with physical, speech, and occupational therapies. Prior authorization is required after 6 visits.)	Yes	$75 Copay	Not Covered 100% paid by Member
Second Surgical Opinion	No	$0 Copay	Not Covered 100% paid by Member
Transplant - Facility	Yes	$400 Copay (After copay, benefit subject to RBP)	
Transplant - Physician and Anesthesiologist Charges during Inpatient Hospitalization	Yes	Benefit subject to RBP	

IHP | Ultimate

Plan Provisions		Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Treatment for Chemical Abuse & Dependency	**(In-Patient)**	**Yes**	$250 Copay per day (After copay, benefit subject to RBP)	
Treatment for Chemical Abuse & Dependency	**(Out-Patient)**	**Yes**	$25 Copay per day	$25 Copay per day

PHARMACY BENEFITS		Participating Pharmacies	Non-Participating Pharmacies
		Member Pays	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic - $0 Copay (Limited to Preventive Generic)	Not Covered 100% paid by Member
Non-Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply (Specialty Drugs and Compounds are not covered)		Generic - $5 Copay Preferred Brand - $40 Copay Non-Preferred Brand - $80 Copay	Not Covered 100% paid by Member
Pharmacy Mail Order – 90-day supply		Generic - $15 Copay Preferred Brand - $120 Copay Non-Preferred Brand - $240 Copay	Not Covered 100% paid by Member
Non-Limited Brand, & Specialty Drugs		Not Covered 100% paid by Member	Not Covered 100% paid by Member

IHP | Ultimate

Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
   a. Sports,
   b. Camp,
   c. Employment,
   d. Travel,
   e. Insurance,
   f. Marriage,
   g. Legal proceedings
2. Routine foot care for treatment of the following:
   a. Flat feet,
   b. Corns,
   c. Bunions,
   d. Calluses,
   e. Toenails,
   f. Fallen arches,
   g. Weak feet,
   h. Chronic foot strain
3. Dental procedures
4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by any appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Any claim related to an injury arising out of, or in the course of, any employment for wage or profit that would be covered by other coverage for which the member is eligible
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to an act of war, declared or undeclared, not including acts of terrorism
14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
15. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational
21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change

IHP | Ultimate

Exclusions

24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant

25. Any claims for fertility or infertility treatment

26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits

27. Claims for disability resulting from reversal of sterilization

28. Claims for the completion of forms, or failure to keep scheduled appointments

29. Recreational or diversional therapy

30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider

31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding

32. Claims that arise primarily due to medical tourism

33. Supportive devices of the foot

34. Treatments for sexual dysfunction

35. Aquatic or massage therapy

36. Biofeedback training

37. Skilled nursing facilities

38. Private duty nursing, or long-term care

39. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury

40. Claims for temporomandibular joint syndrome

41. Claims for biotech or specialty prescriptions

42. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs

43. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.

44. Acupuncture

45. Alternative medicine/homeopathy

46. Children dental and vision

47. Routine eye care (Adult)

48. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands

49. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded.

50. Use of Emergency Room Services for non-emergency care

51. Diagnosis and treatment for sleep apnea

52. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).

53. Gene therapy

54. Emerging gene and cell therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.