imagine360

Navajo Express, Inc.

HDHP

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Group #H880315

DEDUCTIBLE AND ANNUAL OUT-OF-POCKET MAXIMUM	FACILITIES AND PHYSICIANS	NON-PPO PHYSICIANS 2), 3), 4)
Calendar Year Deductible - Per Covered Person - Family Limit	$2,800 $8,400	
Calendar Year Out-of-Pocket Maximum (includes Deductible and all Rx Expenses) - Per Covered Person - Family Limit	$6,550 $13,100	

FACILITY BENEFITS – Payment Levels:

This section applies to covered expenses for services rendered by Hospitals and other types of facilities.

BENEFIT PERCENTAGE FOR:	FACILITY BENEFITS 1)	MAXIMUM BENEFITS, LIMITS & PROVISIONS
Inpatient Hospital Services	80% after Deductible	Contact Imagine360 for coordination of care.
Maternity Inpatient Hospital Services	80% after Deductible	Contact Imagine360 for coordination of care.
Routine Newborn Care Inpatient Hospital Services	80% after Deductible	
Skilled Nursing Facility/Rehabilitation Facility	80% after Deductible	Contact Imagine360 for coordination of care. Limited to 100 visits per Calendar Year.
Hospital Services for Mental/ Nervous Disorders, Chemical Dependency, Drug and Substance Abuse Inpatient/Residential Treatment Facilities	80% after Deductible	Contact Imagine360 for coordination of care.
Hospital Emergency Room (all related charges)	100% after Deductible	Contact Imagine360 for coordination of care.
Outpatient Surgical Facility	80% after Deductible	
Outpatient Therapy/Other Services Physical/Occupational/Speech Therapy	80% after Deductible	Limited to 60 visits per therapy per Calendar Year.
Outpatient Diagnostic Services Select Diagnostic Procedures (CT Scans, MRIs, PET Scans, etc.)	80% after Deductible	
All Other Diagnostic Lab/X-ray	80% after Deductible	
Preventive and Wellness Lab and X-ray	100%; Deductible waived	

1) There is no PPO Hospital Network on this Plan. The PPO Network is a Physician Only PPO Network. Allowable Claim Limits apply to Hospital/Facility charges.

PHYSICIAN BENEFITS – Payment Levels and Limits:

This section applies to Physicians and all other Providers of service not included as Facility Providers.

BENEFIT PERCENTAGE FOR:	IN-NETWORK PHYSICIANS 2), 3)	MAXIMUM BENEFITS, LIMITS & PROVISIONS
Physician Hospital Visits/Surgeon/Anesthesia	80% after Deductible	
Physician Hospital Visit for Mental & Nervous Disorders/Chemical Dependency, Drug and Substance Abuse	80% after Deductible	
Maternity (Including Prenatal delivery and Postnatal care)	80% after Deductible	Contact Imagine360 for coordination of care.
Routine Newborn Care (Pediatric care to date of mother's discharge.)	80% after Deductible	
Office Visit (includes Exam, treatment, surgery, allergy injections/testing/serum)	80% after Deductible	
Mental/Nervous Disorders and Substance Abuse Office Visits	80% after Deductible	
Urgent Care Facility Physician Medical Care	80% after Deductible	
Chiropractic Services	80% after Deductible	Limited to 30 visits per Calendar Year.
Select Diagnostic Medical Procedures CT Scans, MRIs, PET Scans, etc.(Physician's Office or Freestanding Facility)	80% after Deductible	
Diagnostic Lab/X-ray	80% after Deductible	
Outpatient Therapy/Other Services Physical/Occupational/Speech Therapy	80% after Deductible	Limited to 60 visits per therapy per Calendar Year.
Home Health Services	80% after Deductible	Contact Imagine360 for coordination of care. Limited to 120 visits per Calendar Year.
Hospice (Inpatient and Home)	80% after Deductible	Contact Imagine360 for coordination of care.
Durable Medical Equipment	80% after Deductible	Contact Imagine360 for coordination of care.
Prosthetic Devices and Orthotics	80% after Deductible	
Ambulance Services	100% after Deductible	Contact Imagine360 for coordination of care.
All Other Provider Covered Physician Services	80% after Deductible	

2) This plan is a PPO Physician Only plan. Benefits shown in this summary apply to Network and Non-Network provider services..
3) Plan limits apply collectively/combined for Network and Non-Network services.

Preventive and Wellness Care Benefits

This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam/or as specified below.

BENEFIT PERCENTAGE FOR:	PHYSICIAN BENEFITS 2), 3), 4)	LIMITS & PROVISIONS
All Covered Wellness Benefits	100%; Deductible waived	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1) Routine Physical Exam
2) Annual Well Woman Exam
3) *Annual Pap smear and other routine lab
4) *Annual Routine Mammogram
5) *Bone Density test
6) Annual PSA test (routine) – age 40 and older
7) Well Baby Care Exam/Well Child Care Exam
8) Vision Screenings (to age 19)
9) Hearing Screenings for newborns
10) Routine Immunizations
11) Flu vaccine/pneumonia vaccine
12) *Routine lab, x-ray, diagnostic testing and other medical screenings
13) Annual Routine Vision Exam
14) Smoking/Tobacco Use Cessation
15) *All FDA-approved Women's Contraceptive methods/Sterilization procedures
16) *Routine Colonoscopy (includes polyp removal) – age 50 and older or family history of colon cancer

4) This plan is a PPO Physician Only plan. Benefits shown in this summary apply to Network and Non-Network provider services.
5) A 10% lesser benefit coinsurance rate applies to Non-PPO providers (does not apply to Emergency Room Physician, Ambulance and Preventive Services). Usual and Customary fees apply to Non-PPO physician provider services.
6) Plan limits apply collectively/combined for Network and Non-Network services.

* If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.

PRESCRIPTION DRUGS	
Benefits apply after Deductible	
Retail (30 day supply)	Generic: $10 Copay Preferred Brand: $35 Copay Non-Preferred Brand: $60 Copay
Mail Order (90 day supply)	Generic: $25 Copay Preferred Brand: $87.50 Copay Non-Preferred Brand: $150 Copay
Specialty Drugs (30 day supply)	Retail: $60 Copay Mail Order: $150 Copay

NOTE: This Summary of Benefits only represents an overview of your medical benefits and are subject to change.