

# A Smarter Way to Get Health Benefits

Since 1983, **Evolve Association** has been proud to provide our members with **affordable health benefits**, quick and personalized customer service, and professional guidance for you and your family's medical care. We are the experts in the medical insurance industry, and we're here to help you navigate your options.



## United Health & Welfare Explanation of Benefits

Presented by

**EVOLVE ASSOCIATION**

[evolveassociation.com](http://evolveassociation.com)

# HOSPITAL PLAN

## Key Advantages of Joining an Association

Joining an association for your health benefits is a smart choice, especially if you're a self-employed individual, a small business owner, or an employee looking for better options.



### Group Health Advantages

Associations negotiate group plans that are more affordable than individual plans



### Bulk Buying Power Lower Costs

We leverage the buying power of our many members to secure discounts on premiums, deductibles, and co-pays. Including prescription costs insurance plans.



### Simplified Enrollment and Administration

Dedicated support to help you with enrollment, plan selection, and claims. We handle the administrative work.

Because the cost and risk are spread across a larger pool of people, this collective bargaining power gets you better coverage options and lower premiums. You can get access to plans that might otherwise be unavailable.



# MORE COMPREHENSIVE BENEFITS

## GROUP PLANS INCLUDE PERKS YOU MAY NOT FIND IN INDIVIDUAL POLICIES

- + Preventive care at no extra cost
- + Employee assistance programs
- + Telehealth and mental health services
- + Better rates on bundled dental and vision



### Stronger Consumer Protections

Group plans are typically protected by the Employee Retirement Income Security Act (ERISA), which helps safeguard your benefits. As a member, you also have a clear process for grievances and appeals.



### Eligibility Flexibility

Our association allows self-employed individuals, independent contractors, and small business owners to get benefits they couldn't get on their own.



### Additional Evolve Perks and Discounts

As a member, you can save an average of \$1,600 per year in travel, entertainment, and on ever day purchases, and much more.



# WHY EVOLVE ASSOCIATION PLANS ARE DIFFERENT

Our plans are [Major Medical Comprehensive plans](#), which provide true medical coverage. They are not short-term, non-insurance, or healthcare-sharing plans that leave you exposed to the risk of nonpayment for your care.



## Control Your Healthcare Costs

We believe controlling your healthcare costs is the most important task we perform. This allows us to pay claims within 25 days of receiving all required billing and level your premiums year after year.



## Significant Pharmacy Savings

You also become a member of Shield Pharmacy Benefits, which delivers quantifiable savings—typically [\\$1,000 to \\$1,800 per person annually](#).

## Nation's [Largest Network](#) for Outpatient Care

For outpatient care, you become a member of the Multi-Plan PHCS Network, the nation's largest and most comprehensive independent PPO network. It offers access in all 50 states and includes more than 700,000 healthcare professionals, 4,500 hospitals, and 70,000 ancillary care



# YOUR CHOICE OF HOSPITAL, NOT A NETWORK

Take control of your medical care! You get to choose the hospital where you receive treatment, not a network. Our team will provide savings that equal **40% to 65%** of in-hospital charges.

## TWO TYPES OF CARE

Your medical care is divided into two types:

**In-Hospital  
Care**

**Out Patient  
Care**

*Your deductible does not apply to your most common out-patient treatments.*

## Important Facts to Consider

When you're deciding on a medical plan, keep these facts in mind:

- + The average person does not meet their full deductible. **Studies show that only about 10-20% of enrollees meet their full annual deductible in a given year.** The other 80-90% pay some out-of-pocket but don't max it out.
- + The average person is not hospitalized each year. **Only about 3-4% of the general population enters the hospital annually.** For children, it's around 2-3% per year.



***Choosing the right plan is about finding the best fit for your life, and we're here to help.***

# MAJOR MEDICAL OVERVIEW

| PPO Premier Services                                                                                                                                                       |                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| Primary Care                                                                                                                                                               | \$30 co-payment per visit 100% thereafter                                                                                          |
| Teledemed Visit                                                                                                                                                            | \$0 with www.1800md.com                                                                                                            |
| Specialist                                                                                                                                                                 | \$75 co-pay per visit 100% thereafter                                                                                              |
| Mental Health                                                                                                                                                              | \$60 co-pay per visit 100% thereafter                                                                                              |
| Substance Abuse                                                                                                                                                            | \$60 co-pay per visit 100% thereafter                                                                                              |
| Diagnostic Testing<br>Doctors Office, Lab, X-rays & Imaging                                                                                                                | \$30 co-pay per visit 100% thereafter                                                                                              |
| Hospital Emergency Room                                                                                                                                                    | \$600 co-pay per visit for facility<br>\$600 co-pay per visit for physician<br>Co-payment waived if admitted directly from the ER. |
| Urgent Care Visits                                                                                                                                                         | \$60 co-pay per visit 100% thereafter                                                                                              |
| Supplemental Services                                                                                                                                                      |                                                                                                                                    |
| 017291                                                                                                                                                                     |                                                                                                                                    |
| Occupational Therapy                                                                                                                                                       | 60% per visit (limit 20 visits per plan year)                                                                                      |
| Physical Therapy                                                                                                                                                           | 60% per visit (limit 20 visits per plan year)                                                                                      |
| Speech Therapy                                                                                                                                                             | 60% per visit (limit 10 visits per plan year)                                                                                      |
| Private Duty Nurse                                                                                                                                                         | 60% per visit (limit 10 visits per plan year)                                                                                      |
| Non-Surgical Treatment of the Spine                                                                                                                                        | 60% - \$1000 per visit per plan year                                                                                               |
| TMJ                                                                                                                                                                        | 60% \$1,000 Lifetime Maximum                                                                                                       |
| Allergy Treatment                                                                                                                                                          |                                                                                                                                    |
| Testing and Injections                                                                                                                                                     | \$30 co-pay per visit 100% thereafter                                                                                              |
| Serum                                                                                                                                                                      | \$100 co-pay per visit 100% thereafter                                                                                             |
| Prescriptions                                                                                                                                                              |                                                                                                                                    |
| Prescription Drugs                                                                                                                                                         | \$20/\$50/\$80/50%                                                                                                                 |
| Generic/Formulary/Non-Formulary Drugs/Specialty Drugs                                                                                                                      | 2 times Mail-Order; SEE NOTE*                                                                                                      |
| <i>You pay 60% of the cost until you have paid your out-of-pocket maximum, after paying the maximum out of pocket amount this plan covers 100% of the remaining costs.</i> |                                                                                                                                    |
| DEDUCTIBLE APPLIED                                                                                                                                                         |                                                                                                                                    |
| Plan Year Deductibles                                                                                                                                                      | \$3,500 Individual<br>\$7,000 Family                                                                                               |
| Out-of-Pocket Maximum<br>(Non-PPO providers do not satisfy the PPO provider Out-of-Pocket)                                                                                 | \$ 7,000 per Individual<br>\$ 15,000 per Family                                                                                    |

| DEDUCTIBLE APPLIED                  |                                                                                                                                                                                                               |                                                                                     |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| In-Patient Hospital Services        | You choose your hospital                                                                                                                                                                                      | 60% after Deductible                                                                |
| Medical Services and Facility       |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Anesthesiologist and Surgeon Fees   |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| (Assistants at 20% of Primary)      |                                                                                                                                                                                                               |                                                                                     |
| Mental Health and Substance Abuse   |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Out-Patient Surgical and Diagnostic | Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved). |                                                                                     |
| Medical Services                    |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Facility Charges                    |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Emergency Services                  | Urgent care visits include charges for diagnostic, surgical or medical procedures.                                                                                                                            |                                                                                     |
| Durable Medical Equipment           |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Epidural Injections                 |                                                                                                                                                                                                               | 60% after Deductible (Limit 10 visits per plan year)                                |
| Home Health                         |                                                                                                                                                                                                               | 60% after Deductible (Limit 50 visits per plan year)                                |
| Skilled Nursing                     |                                                                                                                                                                                                               | 60% after Deductible (Limit 30 days per plan year)                                  |
| Ambulance - Ground                  |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Ambulance - Air                     |                                                                                                                                                                                                               | Deductible, then covered at 60%<br>Limit \$7,500 maximum per trip for air ambulance |

Network Providers have agreed to accept the Maximum Allowable Charge (MAC) as payment in full. Please refer to your Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits.

Non-Network providers and Care are not covered benefits for out-patient care. You must be in-network to receive benefits for out-patient treatment and medical care.

In-Hospital Benefits are provided for any eligible benefits without a net-work provider required. You choose the hospital to receive medical care.

**Pre-Certification Penalty:** Certain procedures or medical care require pre-certification in order to qualify for full benefits. Failure to pre-certify will result in a \$400 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.

**Emergency Admissions Penalty:** In the case of an Emergency Admission, the member must call the toll-free number listed on the medical identification card within 48 hours after admission or on the next

**Copayments:** Copayment does not apply towards deductibles or coinsurance but does apply to maximum out-of-pocket limits

**Please Note:** This schedule applies as indicated in the SPD. This schedule must be read in conjunction with the entire Summary Plan Description and has no full meaning by itself.

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|                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Plan Year Deductible                                                                                                                                                                                    | An individual with family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions. Eligible claims incurred in the PPO.                                                                                                                                                                                                |
| Coinsurance                                                                                                                                                                                             | Coinsurance is the share of the cost of a covered service, calculated as a percent of the allowed amount of the service.                                                                                                                                                                                                                                                                                                      |
| Out-of-Pocket Maximum                                                                                                                                                                                   | All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual with family coverage will only be required to meet the individual out-of-pocket maximum. Eligible claims incurred in the PPO Network apply to the Out-of-Network Out-of-Pocket Maximum; however, the Out-of-Network eligible claims do NOT apply to the PPO Network Out-of-Pocket Maximum. |
| Preventative Care                                                                                                                                                                                       | In-Network charges for preventive care services coverage are at no cost sharing. Out-of-Network preventive care is not covered. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventative care services.) Although not required under the law, this plan pays for Prostatic/Testicular exams.                                                                  |
| <ul style="list-style-type: none"> <li>Out-Patient Office Visits</li> <li>Primary Care</li> <li>Specialist</li> </ul>                                                                                   | These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician.                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>Mental Health</li> <li>Substance Abuse</li> </ul>                                                                                                                | Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.                                                                                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>Independent Diagnostic Testing Facility</li> <li>X-rays &amp; Advanced Imaging (e.g., MRI, MRA, PET, CT)</li> <li>Out-Patient Surgical and Diagnostic</li> </ul> | These charges are billed by an independent facility, separate from any charges billed by the requesting physician.                                                                                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>Medical Services</li> <li>Facility Charges</li> </ul>                                                                                                            | Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).                                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Emergency Services</li> <li>Hospital Emergency Room</li> <li>Urgent care Visits</li> <li>Ambulance - Ground</li> <li>Ambulance - Air</li> </ul>                  | Urgent care visits include charges for diagnostic, surgical or medical procedures.                                                                                                                                                                                                                                                                                                                                            |
| Prescription Drugs                                                                                                                                                                                      | If generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand-name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.                                                                                                                              |
| Short-Term Rehabilitation Services                                                                                                                                                                      | Includes therapies performed in the provider's office or non-hospital based facility only.                                                                                                                                                                                                                                                                                                                                    |

# MAJOR MEDICAL OVERVIEW

| PPO Advantage                                                                                                                                                              |                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Services                                                                                                                                                                   |                                                                                                                                                            |
| Primary Care                                                                                                                                                               | \$30 co-payment per visit 100% thereafter                                                                                                                  |
| Teled Med Visit                                                                                                                                                            | \$0 with www.1800md.com                                                                                                                                    |
| Specialist                                                                                                                                                                 | \$75 co-pay per visit, 100% thereafter                                                                                                                     |
| Mental Health                                                                                                                                                              | \$60 co-pay per visit, 100% thereafter                                                                                                                     |
| Substance Abuse                                                                                                                                                            | \$60 co-pay per visit, 100% thereafter                                                                                                                     |
| Diagnostic Testing<br>Doctors Office, Lab, X-rays & Imaging                                                                                                                | \$30 co-pay per visit, 100% thereafter                                                                                                                     |
| Hospital Emergency Room                                                                                                                                                    | \$600 co-pay per visit for facility<br>\$600 co-pay per visit for physician<br>Copays waived if admitted directly to the Hospital from the Emergency Room. |
| Urgent Care Visits                                                                                                                                                         | \$60 co-pay per visit 100% thereafter                                                                                                                      |
| Supplemental Services                                                                                                                                                      |                                                                                                                                                            |
| Occupational Therapy                                                                                                                                                       | 65% per visit (limit 20 visits per plan year)                                                                                                              |
| Physical Therapy                                                                                                                                                           | 65% per visit (limit 20 visits per plan year)                                                                                                              |
| Speech Therapy                                                                                                                                                             | 65% per visit (limit 10 visits per plan year)                                                                                                              |
| Private Duty Nurse                                                                                                                                                         | 65% per visit (limit 10 visits per plan year)                                                                                                              |
| Non-Surgical Treatment of the Spine                                                                                                                                        | 65% - \$1000 per visit per plan year                                                                                                                       |
| TMJ                                                                                                                                                                        | 65% \$1,000 Lifetime Maximum                                                                                                                               |
| Allergy Treatment                                                                                                                                                          |                                                                                                                                                            |
| Testing and Injections                                                                                                                                                     | \$30 co-pay per visit 100% thereafter                                                                                                                      |
| Serum                                                                                                                                                                      | \$100 co-pay per visit 100% thereafter                                                                                                                     |
| Prescriptions                                                                                                                                                              |                                                                                                                                                            |
| Prescription Drugs                                                                                                                                                         | \$20/\$50/\$80/50%                                                                                                                                         |
| Generic/Formulary/Non-Formulary Drugs/Specialty Drugs                                                                                                                      | 2 times Mail-Order; SEE NOTE*                                                                                                                              |
| <i>You pay 60% of the cost until you have paid your out-of-pocket maximum, after paying the maximum out of pocket amount this plan covers 100% of the remaining costs.</i> |                                                                                                                                                            |
| DEDUCTIBLE APPLIED                                                                                                                                                         |                                                                                                                                                            |
| Plan Year Deductibles                                                                                                                                                      | \$5,500 Individual<br>\$10,000 Family                                                                                                                      |
| Out-of-Pocket Maximum                                                                                                                                                      | \$ 9,150 per Individual                                                                                                                                    |
| (Non-PPO providers do not satisfy the PPO provider Out-of-Pocket)                                                                                                          | \$ 18,300 per Family                                                                                                                                       |

| DEDUCTIBLE APPLIED                  |                                                                                                                                                                                                               |                                                                                     |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| In-Patient Hospital Services        | You choose your hospital                                                                                                                                                                                      | 65% after Deductible                                                                |
| Medical Services and Facility       |                                                                                                                                                                                                               | 65% after Deductible                                                                |
| Anesthesiologist and Surgeon Fees   |                                                                                                                                                                                                               | 65% after Deductible                                                                |
| (Assistants at 20% of Primary)      |                                                                                                                                                                                                               |                                                                                     |
| Mental Health and Substance Abuse   |                                                                                                                                                                                                               | 65% after Deductible                                                                |
| Out-Patient Surgical and Diagnostic | Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved). |                                                                                     |
| Medical Services                    |                                                                                                                                                                                                               | 65% after Deductible                                                                |
| Facility Charges                    |                                                                                                                                                                                                               | 65% after Deductible                                                                |
| Emergency Services                  | Urgent care visits include charges for diagnostic, surgical or medical procedures.                                                                                                                            |                                                                                     |
| Durable Medical Equipment           |                                                                                                                                                                                                               | 65% after Deductible                                                                |
| Epidural Injections                 |                                                                                                                                                                                                               | 65% after Deductible (Limit 10 visits per plan year)                                |
| Home Health                         |                                                                                                                                                                                                               | 65% after Deductible (Limit 50 visits per plan year)                                |
| Skilled Nursing                     |                                                                                                                                                                                                               | 65% after Deductible (Limit 30 days per plan year)                                  |
| Ambulance - Ground                  |                                                                                                                                                                                                               | 65% after Deductible                                                                |
| Ambulance - Air                     |                                                                                                                                                                                                               | Deductible, then covered at 60%<br>Limit \$7,500 maximum per trip for air ambulance |

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**Pre-Certification Penalty:** Certain procedures or medical care require pre-certification in order to qualify for full benefits. Failure to pre-certify will result in a \$400 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.

**Emergency Admissions Penalty:** In the case of an Emergency Admission, the member must call the toll-free number listed on the medical identification card within 48 hours after admission or on the next

**Copayments:** Copayment does not apply towards deductibles or coinsurance but does apply to maximum out-of-pocket limits

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|                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Plan Year Deductible                                                                                                                                                                                    | An individual with family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions. Eligible claims incurred in the PPO.                                                                                                                                                                                                |
| Coinsurance                                                                                                                                                                                             | Coinsurance is the share of the cost of a covered service, calculated as a percent of the allowed amount of the service.                                                                                                                                                                                                                                                                                                      |
| Out-of-Pocket Maximum                                                                                                                                                                                   | All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual with family coverage will only be required to meet the individual out-of-pocket maximum. Eligible claims incurred in the PPO Network apply to the Out-of-Network Out-of-Pocket Maximum; however, the Out-of-Network eligible claims do NOT apply to the PPO Network Out-of-Pocket Maximum. |
| Preventative Care                                                                                                                                                                                       | In-Network charges for preventive care services coverage are at no cost sharing. Out-of-Network preventive care is not covered. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventative care services.) Although not required under the law, this plan pays for Prostatic/Testicular exams.                                                                  |
| <ul style="list-style-type: none"> <li>Out-Patient Office Visits</li> <li>Primary Care</li> <li>Specialist</li> </ul>                                                                                   | These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician.                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>Mental Health</li> <li>Substance Abuse</li> </ul>                                                                                                                | Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.                                                                                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>Independent Diagnostic Testing Facility</li> <li>X-rays &amp; Advanced Imaging (e.g., MRI, MRA, PET, CT)</li> <li>Out-Patient Surgical and Diagnostic</li> </ul> | These charges are billed by an independent facility, separate from any charges billed by the requesting physician.                                                                                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>Medical Services</li> <li>Facility Charges</li> </ul>                                                                                                            | Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).                                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Emergency Services</li> <li>Hospital Emergency Room</li> <li>Urgent care Visits</li> <li>Ambulance - Ground</li> <li>Ambulance - Air</li> </ul>                  | Urgent care visits include charges for diagnostic, surgical or medical procedures.                                                                                                                                                                                                                                                                                                                                            |
| Prescription Drugs                                                                                                                                                                                      | If generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand-name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.                                                                                                                              |
| Short-Term Rehabilitation Services                                                                                                                                                                      | Includes therapies performed in the provider's office or non-hospital based facility only.                                                                                                                                                                                                                                                                                                                                    |

## UNITED HEALTH &amp; WELFARE

## MAJOR MEDICAL OVERVIEW

| PPO SAVERS                                                                                                                                                                 |                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Services                                                                                                                                                                   |                                                                                                                                                            |
| Primary Care                                                                                                                                                               | \$30 co-payment per visit 100% thereafter                                                                                                                  |
| <a href="#">Telemed Visit</a>                                                                                                                                              | \$0 with www.1800md.com                                                                                                                                    |
| Specialist                                                                                                                                                                 | \$75 co-pay per visit 100% thereafter                                                                                                                      |
| Mental Health                                                                                                                                                              | \$60 co-pay per visit 100% thereafter                                                                                                                      |
| Substance Abuse                                                                                                                                                            | \$60 co-pay per visit 100% thereafter                                                                                                                      |
| Diagnostic Testing<br>Doctors Office, Lab, X-rays & Imaging                                                                                                                | \$30 co-pay per visit 100% thereafter                                                                                                                      |
| Hospital Emergency Room                                                                                                                                                    | \$600 co-pay per visit for facility<br>\$600 co-pay per visit for physician<br>Copays waived if admitted directly to the Hospital from the Emergency Room. |
| Urgent Care Visits                                                                                                                                                         | \$60 co-pay per visit 100% thereafter                                                                                                                      |
| Supplemental Services                                                                                                                                                      |                                                                                                                                                            |
| Occupational Therapy                                                                                                                                                       | 50% per visit (limit 20 visits per plan year)                                                                                                              |
| Physical Therapy                                                                                                                                                           | 60% per visit (limit 20 visits per plan year)                                                                                                              |
| Speech Therapy                                                                                                                                                             | 50% per visit (limit 10 visits per plan year)                                                                                                              |
| Private Duty Nurse                                                                                                                                                         | 60% per visit (limit 10 visits per plan year)                                                                                                              |
| Non-Surgical Treatment of the Spine                                                                                                                                        | 60% - \$1000 per visit per plan year                                                                                                                       |
| TMJ                                                                                                                                                                        | 60% \$1,000 Lifetime Maximum                                                                                                                               |
| Allergy Treatment                                                                                                                                                          |                                                                                                                                                            |
| Testing and Injections                                                                                                                                                     | \$30 co-pay per visit 100% thereafter                                                                                                                      |
| Serum                                                                                                                                                                      | \$100 co-pay per visit 100% thereafter                                                                                                                     |
| Prescriptions                                                                                                                                                              |                                                                                                                                                            |
| Prescription Drugs                                                                                                                                                         | \$20/\$50/\$80/50%                                                                                                                                         |
| <a href="#">Generic/Formulary/Non-Formulary Drugs/Specialty Drugs</a>                                                                                                      | 2 times Mail-Order; SEE NOTE*                                                                                                                              |
| <i>You pay 60% of the cost until you have paid your out-of-pocket maximum, after paying the maximum out of pocket amount this plan covers 100% of the remaining costs.</i> |                                                                                                                                                            |
| DEDUCTIBLE APPLIED                                                                                                                                                         |                                                                                                                                                            |
| Plan Year Deductibles                                                                                                                                                      | \$10,000 Individual<br>\$20,000 Family                                                                                                                     |
| Out-of-Pocket Maximum<br>(Non-PPO providers do not satisfy the PPO provider Out-of-Pocket)                                                                                 | \$ 15,000 per Individual<br>\$ 30,000 per Family                                                                                                           |

| DEDUCTIBLE APPLIED                  |                                                                                                                                                                                                               |                                                                                     |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| In-Patient Hospital Services        | You choose your hospital                                                                                                                                                                                      | 0% after Deductible                                                                 |
| Medical Services and Facility       |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Anesthesiologist and Surgeon Fees   |                                                                                                                                                                                                               | 0% after Deductible                                                                 |
| (Assistants at 20% of Primary)      |                                                                                                                                                                                                               |                                                                                     |
| Mental Health and Substance Abuse   |                                                                                                                                                                                                               | 0% after Deductible                                                                 |
| Out-Patient Surgical and Diagnostic | Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved). |                                                                                     |
| Medical Services                    |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Facility Charges                    |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Emergency Services                  | Urgent care visits include charges for diagnostic, surgical or medical procedures.                                                                                                                            |                                                                                     |
| Durable Medical Equipment           |                                                                                                                                                                                                               | 0% after Deductible                                                                 |
| Epidural Injections                 |                                                                                                                                                                                                               | 60% after Deductible (10 per plan year)                                             |
| Home Health                         |                                                                                                                                                                                                               | 60% after Deductible (50 per plan year)                                             |
| Skilled Nursing                     |                                                                                                                                                                                                               | 60% after Deductible (30 days per plan year)                                        |
| Ambulance - Ground                  |                                                                                                                                                                                                               | 60% after Deductible                                                                |
| Ambulance - Air                     |                                                                                                                                                                                                               | Deductible, then covered at 60%<br>Limit \$7,500 maximum per trip for air ambulance |

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**Emergency Admissions Penalty:** In the case of an Emergency Admission, the member must call the toll-free number listed on the medical identification card within 48 hours after admission or on the next

**Copayments:** Copayment does not apply towards deductibles or coinsurance but does apply to maximum out-of-pocket limits

**Please Note:** This schedule applies as indicated in the SPD. This schedule must be read in conjunction with the entire Summary Plan Description and has no full meaning by itself.

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|                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Plan Year Deductible                                                                                                                                                                                    | An individual with family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions. Eligible claims incurred in the PPO.                                                                                                                                                                                                |
| Coinsurance                                                                                                                                                                                             | Coinsurance is the share of the cost of a covered service, calculated as a percent of the allowed amount of the service.                                                                                                                                                                                                                                                                                                      |
| Out-of-Pocket Maximum                                                                                                                                                                                   | All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual with family coverage will only be required to meet the individual out-of-pocket maximum. Eligible claims incurred in the PPO Network apply to the Out-of-Network Out-of-Pocket Maximum; however, the Out-of-Network eligible claims do NOT apply to the PPO Network Out-of-Pocket Maximum. |
| Preventative Care                                                                                                                                                                                       | In-Network charges for preventive care services coverage are at no cost sharing. Out-of-Network preventive care is not covered. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventative care services.) Although not required under the law, this plan pays for Prostatic/Testicular exams.                                                                  |
| <ul style="list-style-type: none"> <li>Out-Patient Office Visits</li> <li>Primary Care</li> <li>Specialist</li> </ul>                                                                                   | These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician.                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>Mental Health</li> <li>Substance Abuse</li> </ul>                                                                                                                | Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.                                                                                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>Independent Diagnostic Testing Facility</li> <li>X-rays &amp; Advanced Imaging (e.g., MRI, MRA, PET, CT)</li> <li>Out-Patient Surgical and Diagnostic</li> </ul> | These charges are billed by an independent facility, separate from any charges billed by the requesting physician.                                                                                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>Medical Services</li> <li>Facility Charges</li> </ul>                                                                                                            | Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).                                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Emergency Services</li> <li>Hospital Emergency Room</li> <li>Urgent care Visits</li> <li>Ambulance - Ground</li> <li>Ambulance - Air</li> </ul>                  | Urgent care visits include charges for diagnostic, surgical or medical procedures.                                                                                                                                                                                                                                                                                                                                            |
| Prescription Drugs                                                                                                                                                                                      | If generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand-name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.                                                                                                                              |
| Short-Term Rehabilitation Services                                                                                                                                                                      | Includes therapies performed in the provider's office or non-hospital based facility only.                                                                                                                                                                                                                                                                                                                                    |

# A Smarter Way to Get Health Benefits

presented by:



## Helping Americans Access Affordable Healthcare

At Evolve Association, our mission is simple: to help everyday Americans take back control of their healthcare and reclaim the security, stability, and opportunities they've worked so hard to achieve.

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