

# Elon University

Policy # 704685

## *Plan A (Choice Plus)*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from the Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, your plan only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

### *Some of the Important Benefits of Choice Plus Plan include:*

Visit any doctor in the Choice network in your area, including specialists, without designating a primary physician.

Visit any network hospital in your area.

You can choose to seek services outside the network, normally at a higher copayment and/or deductible.

Emergencies are covered anywhere in the world.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery, when covered health services are provided.

Prenatal care is included.

Routine check-ups are included.

Childhood immunizations are provided.

Mammograms are included.

Pap smears are included.

Hearing screenings are covered.

Care Coordination<sup>SM</sup> services are available to help identify and prevent delays in care for those who might need specialized help.

# Plan A (Choice Plus) Benefits Summary

## Types of Coverage

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.**

If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail.

Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.

Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.

Network health care services under this benefit plan are covered only when provided, arranged, or authorized by a Network Physician.

\*Prior Notification is required for certain services received from non-Network providers.

## Network Benefits / Copayment Amounts

### WHAT YOU PAY!

**Annual Deductible:** \$500 per Covered Person per calendar year, not to exceed \$1,500 for all Covered Persons in a family. (cross applies)

**Out-of-Pocket Maximum:** \$3,000 per Covered Person per calendar year, not to exceed \$6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in the SPD. (cross applies)

**Maximum Plan Benefit:** \$1,000,000 per Covered Person (cross applies).

## Non-Network Benefits / Copayment Amounts

### WHAT YOU PAY!

**Annual Deductible:** \$1,500 per Covered Person per calendar year, not to exceed \$4,500 for all Covered Persons in a family. (cross applies)

**Out-of-Pocket Maximum:** \$7,500 per Covered Person per calendar year, not to exceed \$15,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in the SPD. (cross applies)

**Maximum Plan Benefit:** \$1,000,000 per Covered Person (cross applies).

### 1. Ambulance Services - Emergency only

Ground Transportation: 30% of Eligible Expenses after plan deductible

Same as Network Benefit

Air Transportation: 30% of Eligible Expenses after plan deductible

### 2. Dental Services - Accident only

\*30% of Eligible Expenses after plan deductible

Same as Network Benefit

\*Prior notification is required before follow-up treatment begins.

### 3. Durable Medical Equipment

Network and Non-Network Benefits are limited to \$10,000 per calendar year.

Hearing Aids Network and Non-Network Benefits limited to \$10,00 per lifetime

30% of Eligible Expenses after plan deductible

\*50% of Eligible Expenses after plan deductible

\*Prior notification is required when the cost is more than \$1,000

### 4. Emergency Health Services

\$100 per visit

Same as Network Benefit after plan

\*Notification is required if results in an Inpatient Stay.

### 5. Eye Examinations

REFRACTIVE EYE EXAMINATIONS ARE NOT COVERED THROUGH THIS PLAN.

\$45 copay per visit for medical conditions.

50% of Eligible Expenses after plan deductible

REFRACTIVE EYE EXAMINATIONS AND HARDWARE ARE NOT COVERED THROUGH THIS PLAN. See your Vision Services Plan.

REFRACTIVE EYE EXAMINATIONS AND HARDWARE ARE NOT COVERED THROUGH THIS PLAN. See your Vision Services Plan.

### 6. Home Health Care

Network and Non-Network Benefits are limited to 60 visits per calendar year.

100% Coverage

\*50% of Eligible Expenses after plan deductible

### 7. Hospice Care

Network and Non-Network Benefits are limited to a 360 day lifetime maximum benefit.

100% Coverage

\*50% of Eligible Expenses after plan deductible

### 8. Hospital - Inpatient Stay

30% of Eligible Expenses after plan deductible

\$250 per admit copay then \*50% of Eligible Expenses after plan deductible

### 9. Injections Received in a Physician's Office

100% Coverage

50% per injection after plan deductible

### 10. Maternity Services

Same as 8, 11, 12 and 13

Same as 8, 11, 12 and 13

No Copayment applies to Physician office visits for prenatal care after the first visit.

\*Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

# YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts <b>WHAT YOU PAY!</b>	Non-Network Benefits / Copayment Amounts <b>WHAT YOU PAY!</b>
<b>11. Outpatient Surgery, Diagnostic and Therapeutic Services</b>		
Outpatient Surgery (per occurrence)	30% of Eligible Expenses after plan deductible	50% of Eligible Expenses after plan deductible
Outpatient Diagnostic Services (including colonoscopies)	Lab & radiology-- no copayment.	50% of Eligible Expenses after plan deductible
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	30% of Eligible Expenses after plan deductible	50% of Eligible Expenses after plan deductible
Outpatient Therapeutic Treatments	30% of Eligible Expenses after plan deductible	50% of Eligible Expenses after plan deductible
<b>12. Physician's Office Services</b>	\$25 per visit. No Copayment applies when a Physician charge is not assessed.	50% of Eligible Expenses after plan deductible. No Benefits for preventive care.
<b>Specialist's Office Services</b>	\$45 per visit (includes OB/GYN's)	50% of Eligible Expenses after plan deductible. No Benefits for preventive care.
<b>13. Professional Fees for Surgical and Medical Services</b>	30% of Eligible Expenses after plan deductible	50% of Eligible Expenses after plan deductible
<b>14. Prosthetic Devices</b> Network and Non-Network Benefits for prosthetic devices are limited to calendar year maximum of \$10,000	30% of Eligible Expenses after plan deductible	50% of Eligible Expenses after plan deductible
<b>15. Reconstructive Procedures</b>	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
<b>16. Rehabilitation Services -Outpatient Therapy</b>	30% of Eligible Expenses after plan deductible	30% of Eligible Expenses after plan deductible
<b>17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b> Network and Non-Network Benefits are limited to 100 days per calendar year.	30% of Eligible Expenses after plan deductible	*30% of Eligible Expenses after plan deductible
<b>18. Transplantation Services</b>	100% Coverage at a United Resource Networks facility only.	*50% of Eligible Expenses Benefits are limited to \$230,000 per transplant
<b>19. Urgent Care Center Services</b>	\$45 per visit	50% of Eligible Expenses
<b>20. Pharmacy</b>	Retail (31 day supply): Tier 1- \$10 Tier 2- \$35 Tier 3- \$70  Mail Order (90 day supply): Tier 1- \$20 Tier 2- \$70 Tier 3- \$140	Retail: Not covered  Retail: Not covered
<b>Additional Benefits</b>		
<b>Mental Health and Substance Abuse Services – Outpatient</b> Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year.	\$45 per individual visit; \$25 per group visit.	50% of Eligible Expenses after plan deductible (does not accrue to the out-of-pocket maximum)
<b>Mental Health and Substance Abuse Services – Inpatient and Intermediate</b> Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 30 days per calendar year.	\$150 copay per admit, then 30% of Eligible Expenses after plan deductible. Covered expenses do not accrue to the out of pocket maximum.	\$250 copay per admit, then 50% of Eligible Expenses after plan deductible. Covered expenses do not accrue to the out of pocket maximum.
<b>Spinal Treatment</b> Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to a \$10,000 lifetime benefit maximum	\$45 per visit	50% of Eligible Expenses after plan deductible. Covered expenses do not accrue to the out of pocket maximum.
<b>Temporomandibular Joint Syndrome</b> Limited to coverage for Non-Surgical Treatment of TMJ, up to a \$1,000 lifetime maximum benefit.	50% of Eligible Expenses after plan deductible. Covered expenses do not accrue to the out of pocket maximum.	50% of Eligible Expenses after plan deductible. Covered expenses do not accrue to the out of pocket maximum
<b>Podiatric Care</b> Limited to a \$1,000 lifetime maximum benefit.	50% of Eligible Expenses after plan deductible. Covered expenses do not accrue to the out of pocket maximum.	50% of Eligible Expenses after plan deductible. Covered expenses do not accrue to the out of pocket maximum

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the SPD, the following are not covered:

#### A. Alternative Treatments

Acupressure; hypnosis; rolfing; massage therapy; aroma therapy; acupuncture; and other forms of alternative Treatment.

#### B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

#### C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

#### D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

#### E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

#### F. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, cranial banding, gauze and dressings, syringes and diabetic test strips (Refer to Prescription Drug Rider for syringes and diabetic test strips). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

#### G. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Treatment of insomnia and other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

#### H. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

#### I. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, unless hair loss is the result of a medical condition or medical treatment.

#### J. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

#### K. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

#### L. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

#### M. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

#### N. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

#### O. Vision and Hearing

Routine eye examinations. Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

#### P. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

In the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Treatment for temporomandibular joint (TMJ) is limited to non-surgical services only.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecosmastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

Norplant.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.