



2010 Preferred Benefits Plan Summary of Benefits

This summary contains highlights only and is not a complete description of benefits. The Summary Plan Descriptions and Plan documents will govern.
In-Network: co-insurance paid at contracted PPO rate; no balance billing. **Out of Network:** co-insurance paid at Usual and Customary rate; balance billing may apply.

GENERAL PLAN PROVISIONS	IN-NETWORK	OUT OF NETWORK
Calendar Year Deductible (Individual/Family) In-network and Out-of-network deductible is combined, where applicable	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
Provider Network	Network varies by state; see next page, Summary Plan Description (SPD) or www.employersresource.com for network in your area.	
Maximum Limits: PPO and non-PPO plan deductibles, out-of-pocket maximums and plan benefit maximums are combined.	\$3,000 Individual \$6,000 Family (annual out of pocket maximum including deductible)	\$4,000 Individual \$8,000 Family (annual out of pocket maximum including deductible)
Lifetime Maximum	\$1,000,000	
Pre-existing Condition Provision	Pre-existing limitation conditions apply. See next page.	
Pre-certification Requirement	You or your provider must pre-certify certain services and supplies with P5 Care Solutions at least 48 hours in advance of you or your covered dependent receiving them. See next page.	
EMERGENCY AND URGENT CARE	IN-NETWORK	OUT OF NETWORK
Dependent Accident Care: Non-work related accidents are generally covered for eligible dependents at 100%. Employees are covered under the Employers Resource Accident Reimbursement Arrangement Plan.	\$1,000 per covered accident (up to a maximum of \$5,000 per calendar year). No deductible.	
Emergency Room Care: Non-medical emergency is not covered under this plan.	80%, after deductible	
Urgent Care Facility Consultation: Other services (i.e., x-ray, lab work, surgery) provided during visit will be paid as outpatient services subject to the deductible and coinsurance.	\$75 copay, no deductible	
WELLNESS/PREVENTION SERVICES	IMPORTANT FOR TAKING CHARGE OF YOUR HEALTH	
My Health Toolbox: Includes pH test, CBC panel blood test, health risk assessment, newsletters and quality health information.	Included for covered employees and spouses, once per year. Important for knowing and managing health status.	
Routine Well-Child Care (ages 0-6) or Preventive Wellness Care (age 7-up): Includes immunizations, thermograms, hormone assessment, preventive lab/care, OBGYN/prostate cancer prevention.	\$30 copay, \$1,000 annual maximum. Expenses in excess of \$1,000 will be paid as outpatient services.	
OFFICE VISIT CONSULTATION SERVICES	IN-NETWORK	OUT OF NETWORK
Integrative Preferred Professionals: List of nationally-recognized, best-in-class, integrative health professionals at www.myhealthroadmapallstarlist.com .	\$5 copay, no deductible, (INCLUDES lab work if done by preferred professional)	Not applicable
Doctor Office Visits: No network applies unless indicated. Consultation only. Generally DOES NOT include lab/x-rays or minor surgeries.	\$30 copay, no deductible	\$30 copay, no deductible
Chiropractic/Acupuncture/Alternative Care Reimbursement: Services from any licensed practitioner. Includes Eastern medicine, licensed naturopaths or registered dietitians.	100%, no deductible (12 visits per calendar year for Chiropractic /Alternative Care combined). Maximum plan payment: \$35 per visit.	
TREATMENT SERVICES		
Retail and Mail Order Prescription Drugs: See list of Rx exclusions on next page. - Generic, 20% copay - Brand-name, with no generic, 40% copay - Brand-name, if generic available, 60% copay - Mental Health Rx (not covered but discounts available using Prescription Discount Card)	Prescriptions must be filled at PPO pharmacy, otherwise not covered (Employers Resource Benefit Trust Formulary).	
Supplements: i.e. Krill Oil, Pantethine, Non-Flush Niacin, and access to some discounts.	80% reimbursement, up to a calendar year max. plan payment of \$250 (per calendar year, per covered member/dependent).	
Treatment Excellence Centers: Targeted conditions (hip, back and knee surgery, breast and prostate cancer, gall bladder surgery), covered 100% if Treatment Excellence provider recommendations followed. See next page.	100% coverage for using Treatment Excellence Center. 50% coverage if treatment elected outside the Treatment Excellence program.	
HOSPITAL/FACILITY CHARGES	IN-NETWORK	OUT OF NETWORK
In-Patient Hospital Benefit: Pre-certification required.	In-patient copayment of \$500; then 80%, after deductible	In-patient copayment of \$500; then 60%, after deductible
Outpatient Hospital Benefit: Pre-certification may apply.	80%, after deductible	60%, after deductible
Skilled Nursing Facility: Limited to 90 days per year (the first 60 days covered at 80%; next 30 days covered at 50%). Benefit percentage payable does not apply to the out-of-pocket maximum.	80%, after deductible	Not covered
Outpatient Diagnostic X-ray, Labs (Non-Routine): In doctor's office/outpatient basis.	80%, after deductible	60%, after deductible
OTHER COVERED SERVICES	IN-NETWORK	OUT OF NETWORK
In-Patient and Outpatient Mental Health/Substance Abuse	Not covered, EAP benefit available	Not covered, EAP benefit available
Durable Medical Equipment	80%, after deductible	60%, after deductible
Diabetes Education: \$500 annual maximum for educational materials. Network: Dr. Julian Whitaker, Whitaker Wellness Institute.	100%, no deductible applies	60% after deductible

Explanations and Limitations

KEY STEPS IN SELF-DIRECTED CARE (YOU CONTROL YOUR CARE WITH YOUR MEDICAL PROVIDER)

- 1. Assess:** Take a free Health Risk Appraisal through Employers Resource/My Health Toolbox.
- 2. Schedule:** Appropriate preventive check-ups, especially for women over 40 years old (breast cancer) and males over 50 years old (prostate cancer).
- 3. Consult:** Discuss your health with more than your family doctor. Also consult **integrative care practitioners** like chiropractors, naturopaths and registered dietitians.
- 4. Focus on causes, not just symptoms:** Use the Employee Assistance Program to address stress/other personal issues that cause or aggravate health conditions.

PRE-CERTIFICATION REQUIREMENTS: 800-922-1855

- 1. Services: The following services must be pre-certified before receiving care or treatment (or the benefit will be reduced by \$500):**
 - A. Hospital Inpatient Admissions.** All inpatient admissions to any hospital or inpatient facility (e.g. community hospital) with the exception of emergency admissions. Guidelines are:
 - (1) Non-emergency hospital admissions (at least 7 days prior to admission)
 - (2) Emergency hospitalization (within 2 business days of admission)
 - B. Outpatient Surgery Center or Hospital Procedures**
 - C. All MRIs and CT Scans**
 - D. Durable Medical Equipment over \$1,000**
 - E. Surgically Implanted Devices**

P5 Care Solutions (800-922-1855) will analyze your physician's plan of treatment as it applies to the plan's requirements (i.e. medical necessity requirement) and may be able to coordinate medical services and advise you regarding more appropriate use of your health benefits, to help reduce your out-of-pocket expenses.

- 2. Pre-certification and Coverage for Specific Medical Conditions (pre-certification required before treatment or a \$500 penalty and as low as 50% coverage):**
 - A. These Treatment Excellence conditions require pre-certification before receiving ANY care or treatment (see the Summary Plan Description for details):** Breast Cancer, Prostate Cancer, Back Surgery, Gall Bladder Surgery, Hip Surgery, Knee Surgery. **The cost of the Treatment Excellence review is fully covered.**
 - B. If the official Treatment Excellence opinion:**
 - validates the treatment plan prescribed by your doctor: 100% coverage in-network (70% out of network)
 - differs from the treatment plan prescribed by your doctor (and the Treatment Excellence provider IS used): 100% coverage
 - differs from the treatment plan prescribed by your doctor (and the Treatment Excellence provider IS NOT used): 50% coverage

PRESCRIPTION DRUG EXCLUSIONS

- 1. Research:** Know the side effects of prescriptions before use and shop for the best price at <http://www.employersresource.com/employee/e.national-prescription-discount.php>.
- 2. Exclusions:** These prescriptions are excluded from coverage (see Summary Plan Description). *Employers Resource has alternatives for each of these drugs.*
 - *Drugs used to treat mental health conditions*, (i.e. anxiety, depression, ADD, ADHD).
 - *Statin drugs*, including but not limited to: Lipitor, Zocor, Crestor, Pravachol or Vytorin (and generic equivalents).
 - *Synthetic Hormone Replacement Therapy drugs*, including but not limited to: Prempro, Provera, and Premarin.
 - *COX-2 inhibitors*, including but not limited to: Vioxx, Celebrex, and Bextra.
 - *Proton Pump Inhibitors/Acid Reflux medications*, including but not limited to: Nexium, Prevacid, Protonix, Prilosec (and generic equivalents).
 - *Bisphosphonates*, including but not limited to: Fosamax, Boniva and Actonel.
 - *Tumor Necrosis Factor-Alpha (TNF-A) Inhibitors/Blockers*, including but not limited to: Enbrel, Humira, Remicade and Cimzia.
 - *Thiazolidinediones (TZDs)*, including but not limited to: Actos and Avandia.
- 3. Note:**
 - The list above is a selection of drug exclusions. For complete list visit www.employersresource.com or call P5 at 1-800-922-1855.
 - Any prescription purchase over \$400 requires prior authorization through the Pharmacy Benefit Manager. Authorizations are limited to a 90-day supply.

PRE-EXISTING LIMITATIONS AND EXCLUSIONS

- 1. Definition:** A *pre-existing condition* is any illness or injury (excluding pregnancy) for which medical advice, diagnosis, care or treatment (including prescribed drugs or medicines) has been received from a physician or practitioner during the six months immediately prior to your enrollment date.
- 2. Reducing pre-existing limitations:** Limitations may be reduced if you were covered under a medical plan prior to enrollment in this plan, provided the prior plan qualifies as creditable medical coverage. If your creditable coverage was effective and continuous for 12 months immediately prior to the effective date under this plan, and you provide such proof, pre-existing conditions will not apply. To provide proof, obtain a Letter of Creditable Coverage from your prior carrier and submit it to P5 Health Plan Solutions, PO Box 9554, Salt Lake City, UT 84109-0544 (phone: 800-922-1855; fax: 801-412-8550).
- 3. Calculations:** The calculation of days/months of coverage credited does not include: (i) any coverage preceding a break in coverage of 63 days or more; nor (ii) any period of time during an applicable benefits waiting period.

NETWORKS		SUMMARY PLAN DESCRIPTION AND OTHER MEDICAL PLAN INFORMATION	PLEASE NOTE
Arizona	Arizona Foundation (www.azfmc.com)	<ol style="list-style-type: none"> Go to: www.employersresource.com Click on Employee Center, then Benefits, then Medical, then Employers Resource Benefit Trust. Click on the "Detailed Plan Description" for your particular plan. 	This self-funded medical plan offered through Employers Resource Benefit Trust (and sponsored by Employers Resource) is not insurance and does not participate in any state guarantee association.
California	Interplan (www.interplanhealth.com)		
Idaho	IPN (www.ipnmd.com)		
No. Carolina	Medcost (www.medcost.com)		
Others	Refer to (www.employersresource.com)		