UltraBenefits, Inc.

CARY MEDICAL CENTER

Effective 1.1.2021

Benefit	CMC Network (CMC & Pines) St.Joes & ME Med Facility	Preferred Network First Health/Multiplan	Non-Preferred Out of Network
Deductible The amount the member must pay each calendar year before payments begin	$1,000 per individual $2,000 per family	$2,000 per individual $4,000 per family	$3,000 per individual $6,000 per family
Plan Co-Insurance	90%	60%	50%
Maximum Out-of-Pocket The maximum amount that any individual or family pays towards covered expenses during one calendar year.	$3,000 per individual $4,500 per family	$4,000 per individual $6,000 per family	$6,000 per individual $12,000 per family

Covered Medical Expenses	CMC Network (CMC & Pines) St.Joes & ME Med Facility	Preferred Network First Health/Multiplan	Non-Preferred Out of Network
Advanced Imaging	100%	Deductible, then 60%	Deductible, then 50%
Ambulance	Deductible, then 90%	Deductible, then 60%	Deductible, then 50%
Chiropractic Care	Deductible, then 80%	Deductible, then 80%	Deductible, then 80%
Diagnostic Labs (outpatient)	100%	Deductible, then 60%	Deductible, then 50%
Diagnostic X-Ray (outpatient)	100%	Deductible, then 60%	Deductible, then 50%
Durable Medical Equipment	Deductible, then 90%	Deductible, then 90%	Deductible, then 90%
Home Health Care	Deductible, then 90%	Deductible, then 60%	Deductible, then 50%
Oral Surgery	Deductible, then 90%	Deductible, then 60%	Deductible, then 50%
Outpatient ER Services Co-payment waived if admitted	$200 Co-Pay	$200 Co-Pay	$200 Co-Pay
Mental Health/Substance (inpatient)	Deductible, then 90%	Deductible, then 60%	Deductible, then 50%
Mental Health/Substance (outpatient)	$25 Co-Pay	$40 Co-Pay	$50 Co-Pay
Physician Office Visit	$25 Co-Pay	$40 Co-Pay	$50 Co-Pay
Preventative Care			
Routine Physical Exams	100%	$40 Co-Pay	Deductible, then 50%
Routine Mammograms	100%	100%	Deductible, then 50%
Diagnostic Mammograms	100%	Deductible, then 60%	Deductible, then 50%
Routine Pap Smears	100%	100%	Deductible, then 50%
Diagnostic Pap Smears	100%	Deductible, then 60%	Deductible, then 50%
Colonoscopy	100%	100%	Deductible, then 50%
Prostate Exam	100%	100%	Deductible, then 50%
Immunizations	100%	100%	Deductible, then 50%
Pre-Admission Certification Provider or facility may contact Ultra on the employees behalf to obtain pre-certification and authorization.	$300 non compliance penalty	$300 non compliance penalty	$300 non compliance penalty
Routine Vision Exams	$25 Co-Pay	$25 Co-Pay	$25 Co-Pay
Skilled Nursing Facility	Deductible, then 90%	Deductible, then 90%	Deductible, then 90%
Therapy Services (most covered)	Deductible, then 90%	Deductible, then 60%	Deductible, then 50%

NOTE: This Footprint is not all-inclusive. Please refer to the Summary Plan Description for additional details.

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Pharmacy	Network Pharmacy - Alluma/Maxor	
RX Deductible - N/A Per individual Per Family	$200	For Specialty Drugs only
RX Out of Pocket Maximum	No separate Out-of-Pocket Maximum for RX - Is combined with Medical Maximum	

Retail Pharmacy - per refill	Retail (34 Day Supply)	Retail (35-90 Day Supply)
Generic Co-Pay	$10	$20
Perferred Brand	$20	$40
Non-preferred Brand	$40	$80
Specialty Co-Pay/Co-Insurance	Deductible, then 70% to a max copy of $150	N/A

Mail-Order (90 day supply)	Mail-order (XX Day Supply)	Mail-order (90 Day Supply)
Generic Co-Pay	N/A	$20
Perferred Brand	N/A	$40
Non-preferred Brand	N/A	$80
Specialty Co-Pay/Co-Insurance	Deductible, then 70% to a max copy of $150	N/A

NOTE: This Footprint is not all-inclusive. Please refer to the Summary Plan Description for additional details.

1. All Plan benefits in the CMC Network and First Health / Multiplan Network are based on negotiated charges. Non-Preferred Hospitals and Out-of-Network Providers are based on reasonable and customary allowances. Non-Preferred Hospitals who participate with a network are based on negotiated charges.
2. All other covered benefits not listed above will be subject to deductible, then payable at 90% for CMC Network, 60% for First Health / Multiplan Providers, and 50% for Non-Preferred Hospitals & Out-of-Network Providers.
3. All CMC Network, First Health / Multiplan Network, Non-Preferred Hospitals & Out-of-Network benefit maximums are combined.
4. All CMC Network, First Health / Multiplan Network, Non-Preferred Hospitals & Out-of-Network deductible and coinsurance amounts are combined.
5. Medical and prescription drug copayments are applied to the out-of-pocket maximum
6. Precertification penalties are not applied to the deductible or out-of-pocket maximum.
7. When filling a prescription for which a generic drug is available and the covered person chooses the brand name drug, the covered person will be responsible for paying the brand name copayment plus the difference in cost between the generic and the brand name drug. This does not apply to contraceptive drugs.
8. Covered facility services rendered at St. Joseph Hospital will be payable at the CMC Network level and will not be subject to the CMC Network level deductible.
9. Covered facility services rendered at Maine Medical Center will be payable at the CMC Network level.