Spooner Medical Plan Benefits

General Provisions	
Benefit	**All Providers**
Benefit Period	Calendar Year
Deductible (per Calendar Year) Individual Family	 $500 $1,000
Benefits are payable for an individual once the Individual Deductible is met. Each time an individual within the family pays toward his or her individual deductible, that amount is also credited toward the family deductible. Once the family deductible is met, benefits are payable for all family members even if their individual deductibles are not met.	
Member Pays - payment based on the plan allowance	You pay 20% after deductible
Total Maximum Out-of-Pocket (includes Deductible, coinsurance, co-pays, prescription drug cost sharing and other qualified medical expenses. Once met, there is no cost sharing for covered services for the rest of the calendar year). Individual Family	 $6,000 $12,000
Benefits are payable at 100% without any cost share for an individual once the Individual Out-of-Pocket Maximum is met. Each time an individual within the family pays toward his or her individual Out-of-Pocket Maximum, that amount is also credited toward the family Out-of-Pocket Maximum. Once the family Out-of-Pocket Maximum is met, benefits are payable for all family members even if their individual deductibles are not met.	

Physician Office Services		
Services rendered in a physicians office	**Patient Responsibility**	**Approval Required?**
Direct Primary Care (office, home, virtual, phone)	No Cost Share	N/A
Primary Care Physician/Provider (office, home, virtual, phone)	$25 Copay per visit	N/A
Specialty Care Physician/ Provider (office, home, virtual, phone)	$50 Copay per visit	N/A
Lab & X-ray Services including ultrasounds	You pay 20% after deductible No cost share at Ark	N/A
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)	You pay 20% after deductible	14 Day Pre-Approval required
Injections (Physician & Medication)	You pay 20% after deductible	14 Day Precertification required
Office Surgery / Procedure	You pay 20% after deductible	N/A
Allergy Testing	No Cost Share	N/A
Allergy Injections	You pay 20% after deductible	N/A
Allergy Serum	You pay 20% after deductible	N/A
Walk-in Clinics	$25 Copay per visit	N/A

Preventive Care		
Service	**Patient Responsibility**	**Approval Required?**
Routine Pediatric/Adolescent Physical Exams	No Cost Share	N/A
Routine Adult Physical Exams	No Cost Share	N/A
Adult, Pediatric and Adolescent Immunizations	No Cost Share	N/A
Mammograms, Annual Routine	No Cost Share	N/A
Routine Gynecological Exams, including a Pap Test	No Cost Share	N/A
Preventive Contraceptive Management	No Cost Share	N/A
Routine Screening Services	No Cost Share	N/A

Routine Colonoscopy	No Cost Share	N/A
Preventive/Well Care is covered as defined in the Patient Protection and Affordable Care Act, as amended and as described by the Health Resources and Services Administration (HRSA)		

Diagnostic Testing (Independent Laboratory & Freestanding Imaging Facility)		
Service	**Patient Responsibility**	**Approval Required?**
Lab & X-ray Services including ultrasounds	You pay 20% after deductible	N/A
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)	You pay 20% after deductible	14 Day Pre-Approval required
Sleep Study (Freestanding Facility)	You pay 20% after deductible	14 Day Pre-Approval required
Sleep Study (Home)	You pay 20% after deductible	14 Day Pre-Approval required
Emergency Services		
Service	**Patient Responsibility**	**Approval Required?**
Emergency Room (Including Facility, ER Physician, Radiologist, & Pathologist)	You pay $200.00 copay then 20% after deductible per visit (Patient responsibility waived if admitted)	Required to notify Aither within 24 hours after admission.
Urgent Care Office Visit Charge	$50 Copayment per visit	N/A
Ambulance and other medically necessary transportation	You pay 20% after deductible	N/A
Non Emergent Air Ambulance	You pay 20% after deductible	14 Day Precertification required
Surgery		
Service	**Patient Responsibility**	**Approval Required?**
Surgeon	You pay 20% after deductible	14 Day Precertification required
Assistant Surgeon	You pay 20% after deductible	14 Day Precertification required
Anesthesiologist	You pay 20% after deductible	14 Day Precertification required
Pathologist/Radiologist	You pay 20% after deductible	14 Day Precertification required
Transplant Services (Designated Facility Only)	You pay 20% after deductible	14 Day Precertification required

Second Opinion Requirement:
The Plan has a mandatory Second Opinion requirement for most elective surgeries. Prior to scheduling a surgical procedure, you must contact Aither who will help you coordinate the Second Opinion. Failure to comply with the Second Opinion requirement will result in the denial of all claims associated with the surgery. See Second Opinion Requirement List below.

14 Day Precertification Requirement:
All Non-emergent surgical procedures must be precertified 14 days in advance of the surgery. For emergency surgery, you must notify the plan within 24 hours after the surgery or on the first business day following a weekend procedure. Failure to comply with the precertification requirements will result in the denial of all claims associated with the surgery.

BANNER HEALTH | Important Note:
Banner Hospital and all affiliated medical sites are excluded under the Plan. Please contact Aither for help locating an alternative location.

Medical Inpatient Services (Hospital, Medical Rehabilitation, Skilled Nursing Facility)		
Service	**Patient Responsibility**	**Approval Required?**
Inpatient Facility	You pay 20% after deductible	14 Day Precertification required
Physician Inpatient Visit	You pay 20% after deductible	14 Day Precertification required
Inpatient Physician Services (Including pathology & radiology services)	You pay 20% after deductible	14 Day Precertification required
Inpatient Surgery (Includes Surgeon, Assistant, Anesthesiologist, Radiologist, Pathologist) ****See Second Opinion Requirements**	You pay 20% after deductible	14 Day Precertification required
Preadmission Testing	You pay 20% after deductible	N/A
Post Hospitalization Medical Rehab Facility (14 day maximum)	You pay 20% after deductible	14 Day Precertification required
Skilled Nursing Facility (14 day maximum)	You pay 20% after deductible	14 Day Precertification required

14 Day Precertification Requirement:
All Non-emergent inpatient confinements must be precertified 14 days in advance of the admission. For emergency admissions, you must notify the plan within 24 hours after admission or on the first business day following a weekend admission. Failure to comply with the precertification requirements will result in the denial of all claims associated with the admission.

BANNER HEALTH | Important Note:
Banner Hospital and all affiliated medical sites are excluded under the Plan. Please contact Aither for help locating an alternative location.

Medical Outpatient Hospital Services		
Service	**Patient Responsibility**	**Approval Required?**
Outpatient Hospital Clinic	Not Covered	N/A
Outpatient Hospital Visit	Not Covered	N/A
Outpatient Hospital Observation (Emergent only)	You pay 20% after deductible	Required to notify Aither within 24 hours after admission.
Outpatient Surgery (Includes Surgeon, Assistant, Anesthesiologist, Radiologist, Pathologist) ****See Second Opinion Requirements**	You pay 20% after deductible	14 Day Precertification required
Laboratory Services	Not Covered (See **Diagnostic Testing** Section for approved locations)	N/A
X-rays, Ultrasounds	Not Covered (See **Diagnostic Testing** Section for approved locations)	N/A
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)	Not Covered (See **Diagnostic Testing** Section for approved locations)	N/A
Therapy Services (Chemotherapy, Radiation Therapy, Infusion Therapy)	Not Covered (See **Therapy Services** Section for approved locations)	N/A
Cardiac Rehabilitation	Not Covered (See **Therapy Services** Section for approved locations)	N/A
Physical and Occupational Therapy	Not Covered (See **Therapy Services** Section for approved locations)	N/A
Respiratory Therapy	Not Covered (See **Therapy Services** Section for approved locations)	N/A
Speech Therapy	Not Covered (See **Therapy Services** Section for approved locations)	N/A
Applied Behavior Analysis for Autism Spectrum Disorder	Not Covered (See **Therapy Services** Section for approved locations)	N/A

Important Note:
Banner Hospital and all affiliated medical sites are excluded under the Plan. Please contact Aither for help locating an alternative location.

Maternity Services		
Service	**Patient Responsibility**	**Approval Required?**
Prenatal Care - Physician Office Visits	No Cost Share	N/A
Laboratory Services (Office or Independent Laboratory only)	You pay 20% after deductible	N/A
Diagnostic Testing (Office or Freestanding Imaging Facility)	You pay 20% after deductible	N/A
Inpatient Hospital (mom)	You pay 20% after deductible	See below*
Hospital Nursery (newborn)	Well baby covered under mom	See below*
Physician - Delivery Vaginal	You pay 20% after deductible	See below*
Physician - Cesarean Section (Scheduled, Non-Emergent)	You pay 20% after deductible	14 Day Precertification required
Physician - Newborn inpatient well visits	Well baby covered under mom	See below*
Nurse Midwife	You pay 20% after deductible	See below*
Birthing Center	You pay 20% after deductible	See below*
Home Delivery with Nurse Midwife	Not Covered	N/A
Lactation Counseling & Equipment	No Cost Share	N/A

***Precertification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section.**

Therapy and Rehabilitation Services - Office		
Service	**Patient Responsibility**	**Approval Required?**
Acupuncture Treatment	$50 copay per visit	14 Day Pre-Approval required
Applied Behavior Analysis for Autism Spectrum Disorder	$50 copay per visit	14 Day Pre-Approval required
Aquatic Therapy	Not Covered	N/A
Cardiac Rehabilitation (36 visits per calendar year)	$50 copay per visit	14 Day Pre-Approval required
Chemotherapy ***See Second Opinion Requirement**	$50 copay per visit	14 Day Pre-Approval Required Second Opinion Required

Chiropractic Care/Spinal Manipulations	Not Covered	N/A
Dialysis	You pay 20% after deductible	14 Day Pre-Approval required
Holistic or Homeopathic Medicine	Not Covered	N/A
Hyperbaric Treatment	Not Covered	N/A
Infusion Therapy	$50 copay per visit	14 Day Precertification required
Infusion Specialty Medications	You pay 20% after deductible	14 Day Precertification required
Massage Therapy	Not Covered	N/A
Physical and Occupational Therapy performed at Spooner PT (Unlimited Visits per Calendar Year)	No Cost Share	N/A
Physical and Occupational Therapy nor performed at Spooner PT (20 Visit limit per Calendar Year)	Not Covered	N/A
Radiation Therapy ***See Second Opinion Requirement**	You pay 20% after deductible	14 Day Pre-Approval Required Second Opinion Required
Respiratory Therapy (20 visits)	$30 copay per visit	14 Day Pre-Approval required
Speech Therapy (24 Visits per Calendar Year)	$50 copay per visit	14 Day Pre-Approval required
Mental Health Services		
Service	**Patient Responsibility**	**Approval Required?**
Therapy/Counseling Office	$25 Copay per visit	N/A
Psychiatrist Office Visit	$25 Copay per visit	N/A
Inpatient Mental Health Services (Facility)	You pay 20% after deductible	14 Day Precertification required
Inpatient Mental Health Services (Physician)	You pay 20% after deductible	14 Day Precertification required
Inpatient Lab, X-ray, Diagnostic Testing	You pay 20% after deductible	14 Day Precertification required
Outpatient Mental Health Services (Facility)	You pay 20% after deductible	14 Day Precertification required
Outpatient Mental Health Services (Physician)	You pay 20% after deductible	14 Day Precertification required
Mental Health Residential Treatment (Facility & Physician)	You pay 20% after deductible	14 Day Precertification required
Mental Health Partial Hospitalization (Facility & Physician)	You pay 20% after deductible	14 Day Precertification required
Substance Abuse		
Service	**Patient Responsibility**	**Approval Required?**
Therapy/Counseling Office	$25 Copay per visit	N/A
Psychiatrist Office visit	$25 Copay per visit	N/A
Inpatient Detox (Facility)	You pay 20% after deductible	14 Day Precertification required
Inpatient Detox (Physician)	You pay 20% after deductible	14 Day Precertification required
Inpatient Lab, X-ray, Diagnostic Testing	You pay 20% after deductible	14 Day Precertification required
Outpatient Hospital Detox Services (Facility)	You pay 20% after deductible	14 Day Precertification required
Outpatient Hospital Detox Services (Physician)	You pay 20% after deductible	14 Day Precertification required
Inpatient Substance Abuse Rehab (Facility)	You pay 20% after deductible	14 Day Precertification required
Inpatient Substance Abuse Rehab (Physician)	You pay 20% after deductible	14 Day Precertification required
Outpatient Hospital Substance Abuse (Facility)	You pay 20% after deductible	14 Day Precertification required
Outpatient Hospital Substance Abuse (Physician)	You pay 20% after deductible	14 Day Precertification required
Substance Abuse Residential Treatment (Facility & Physician)	You pay 20% after deductible	14 Day Precertification required
Substance Abuse Partial Hospitalization (Facility & Physician)	You pay 20% after deductible	14 Day Precertification required
Other Treatments/Services		
Service	**Patient Responsibility**	**Approval Required?**
Assisted Fertilization Procedures	Not Covered	N/A
Biofeedback	You pay 20% after deductible	N/A

Blood and Plasma	You pay 20% after deductible	N/A
Cochlear Implants	Not Covered	N/A
Dental Services Related to Accidental Injury	You pay 20% after deductible	N/A
Dental Oral Surgery	You pay 20% after deductible	N/A
Diabetic Education	No Cost Share	N/A
Diabetic Supplies	Refer to Pharmacy Benefit	N/A
Durable Medical Equipment and Prosthetics	You pay 20% after deductible	14 Day Precertification required >$500
Genetic Counseling	You pay 20% after deductible	14 Day Precertification required
Genetic Testing	You pay 20% after deductible	14 Day Precertification required
Glaucoma, Cataract Surgery and Lenses (One set)	You pay 20% after deductible	14 Day Precertification required
Hearing Aids & Exams	Not Covered	N/A
Home Health Care (30 visits per calendar year)	You pay 20% after deductible	14 Day Precertification required
Hospice (Respite Care allowed 3 hours, 5x a week)	You pay 20% after deductible	N/A
Hospice (Bereavement Services)	See EAP Program	N/A
Infertility Counseling and Testing (diagnostic)	You pay 20% after deductible	N/A
Medical Supplies	You pay 20% after deductible	N/A
Nutritional Counseling (Office only)	$50 Copay per visit	N/A
Private Duty Nursing	No Covered	N/A
Sexual Function (Diagnostic and Surgical if medically necessary)	You pay 20% after deductible	N/A
Prostate Exam	You pay 20% after deductible	N/A
Second Opinion	No Cost Share	Contact Aither to coordinate
Sexual Function (Diagnostic and Surgical if medically necessary)	You pay 20% after deductible	N/A
Temporomandibular Joint Disorder (TMJ)	Not Covered	N/A
Wigs (hair loss due to cancer treatment or alopecia related to a medical condition)	You pay 20% after deductible	N/A
Prescription Drugs		
Prescription Drug Deductible Individual/Family	None	
Prescription Drug Program	Generic: $15 Copay Brand: $50 Copay Specialty: $150 Copay	
Second Opinion Requirement		
The Plan has a mandatory Second Opinion requirement for most elective non-emergent surgeries and cancer treatments. Prior to scheduling a surgical procedure or treatment, you must contact Aither who will help you coordinate the Second Opinion. Failure to comply with the Second Opinion requirement will result in the denial of all claims associated with the surgery or treatment. The list below is not all inclusive. Contact Aither to determine if the recommended surgery or treatment requires a Second Opinion. All elective inpatient and outpatient surgeries related to the following:		
Heart		
Spine		
Joint / Orthopedics		
Cancer		
Transplants		
Stem Cell Therapy		
Podiatry		

This is not a contract. This benefit summary presents plan highlights only. Please refer to the Summary Plan Description (SPD) as limitations and exclusions apply. The SPD controls in the event of a conflict with this benefits summary.