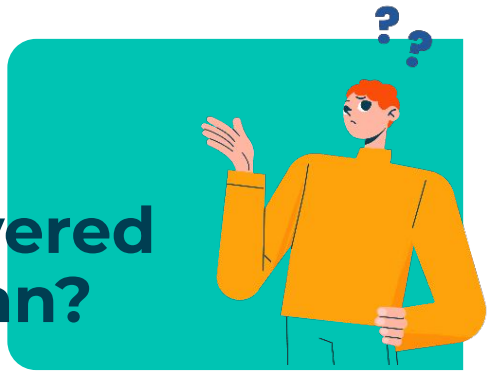
nonstop HEALTH



In-Network Providers and Covered Services...What Does This Mean?

You may only use Nonstop Health to pay for covered services and prescriptions received at in-network providers and facilities. But what does this actually mean? This document explains some of the most common terms associated with Nonstop Health and provides tips and tricks for ensuring you stay in compliance with our program.

Key Terms

Let's start by reviewing key terms that you'll read, see or hear about with Nonstop Health.

In-network: These providers have a contract with your insurance carrier, and have set up a negotiated rate for different services. As such, the provider can only charge a set price for the services you receive. This results in lower costs for you, as in-network providers almost always charge less than out-of-network providers.

Out-of-network: An out-of-network provider has not signed a contract with your carrier, and therefore they can set whatever price they want for healthcare services. It's important to know if and how your carrier covers out-of-network services under your plan, and how the higher prices will impact you.

Covered services: A covered service is one that your carrier has agreed to pay for under your medical plan. Not all services are covered by every plan, so before receiving a new service, check with your carrier. Your carrier may have a cost or visit limit for specified services, or other limitations.

Covered prescriptions: Your carrier will set a "formulary" or drug list, which lists what prescriptions are covered under your medical plan. Just because a doctor prescribes a medication doesn't mean it's automatically covered by your carrier. Before filling and paying for a new prescription, check with your carrier or ask your pharmacist if the medication is covered. If it's not covered, ask your doctor or pharmacist for an alternative covered medication.

Carrier approved: A carrier-approved service or prescription is one that your carrier has agreed to cover as part of your underlying medical plan. This includes covered services and prescriptions. However, it also can indicate that your carrier has given you explicit/written permission to see an out-of-network provider for services and those costs will be considered in-network and covered under your plan.

QUICK TIP!

An easy way to find out if a provider is in-network or a service or prescription is covered by your medical plan is to call/email your health insurance carrier or sign up for an online account with them!

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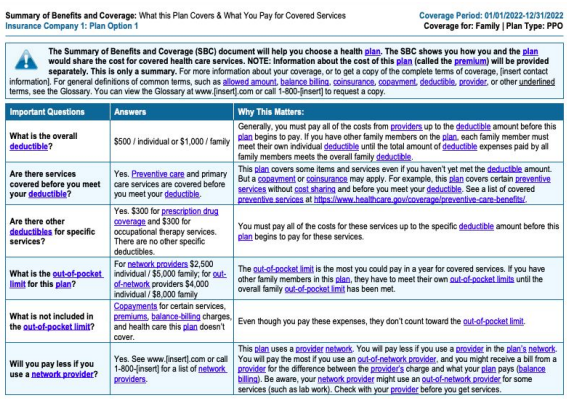
What is a Summary of Benefits and Coverage (SBC)?

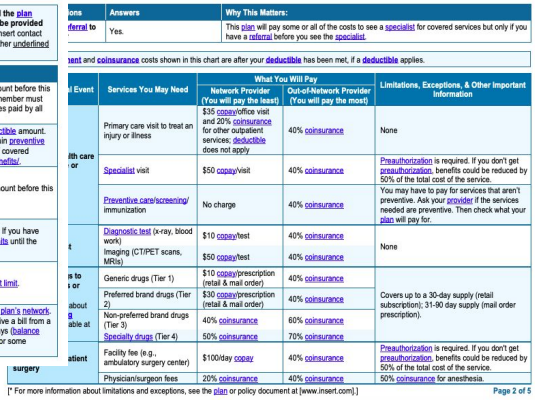
An SBC is one of the quickest ways to find out what your deductible and out-of-pocket maximum are, what services are covered under your medical plan, and any copays or coinsurance you'll be required to pay at the time of service. Find your SBC on the Nonstop Exchange (NSE) member portal under Employee Documents.



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Insurance Company 1: Plan Option 1
Coverage Period: 01/01/2022-12/31/2022
Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 / individual or $1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.



Answers	Why This Matters:
Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	$35 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/visit	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	
	Generic drugs (Tier 1)	$10 copay/prescription (retail & mail order)	40% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail & mail order)	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	40% coinsurance	60% coinsurance	
	Specialty drugs (Tier 4)	50% coinsurance	70% coinsurance	
	Facility fee (e.g., ambulatory surgery center)	$100/day copay	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance for anesthesia.

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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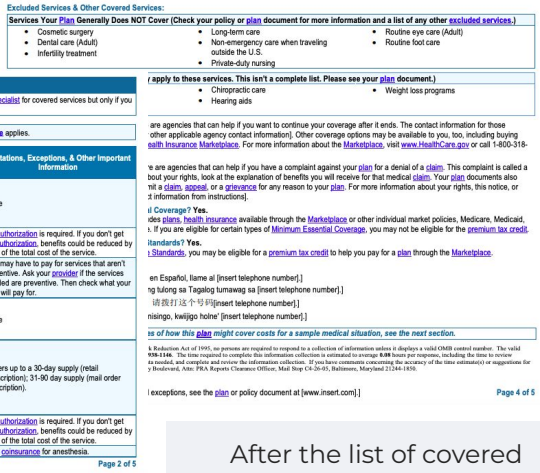

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids
- Weight loss programs

are agencies that can help if you want to continue your coverage after it ends. The contact information for those other applicable agency contact information]. Other coverage options may be available to you, too, including buying ealth Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-

e are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a bout your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also ll a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or t information from instructions].

l Coverage? Yes.
ides plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, . If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Standards? Yes.
Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

en Español, llame al [insert telephone number].]
ng tulong sa Tagalog tumawag sa [insert telephone number].]
请拨打这个号码[insert telephone number].]
nisingo, kwiijgo holne' [insert telephone number].]

e of how this plan might cover costs for a sample medical situation, see the next section.

k Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid 938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review ts needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for y Boulevard, Attn: PRA Reports Clearance Office, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

exceptions, see the plan or policy document at [www.insert.com].]

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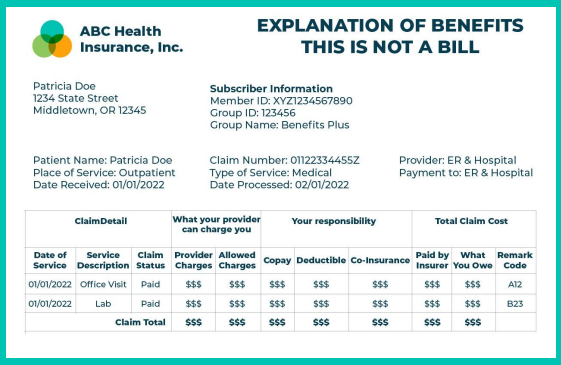
The first page of your SBC will show you the plan name, coverage period, and details on your deductible and out-of-pocket maximum.

The next few pages of your SBC provide a list of common medical events, covered services, copays/coinsurance for in-network and out-of-network providers, and any exceptions for services.

After the list of covered services, you will see a box that shows services that are excluded, as well as a box that shows "other covered services" which typically have limitations applied.

What is an Explanation of Benefits (EOB)?



ABC Health Insurance, Inc.

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

Patricia Doe
1234 State Street
Middletown, OR 12345

Subscriber Information
Member ID: XYZ1234567890
Group ID: 123456
Group Name: Benefits Plus

Patient Name: Patricia Doe
Place of Service: Outpatient
Date Received: 01/01/2022

Claim Number: 01122334455Z
Type of Service: Medical
Date Processed: 02/01/2022

Provider: ER & Hospital
Payment to: ER & Hospital

ClaimDetail			What your provider can charge you		Your responsibility			Total Claim Cost		
Date of Service	Service Description	Claim Status	Provider Charges	Allowed Charges	Copay	Deductible	Co-Insurance	Paid by Insurer	What You Owe	Remark Code
01/01/2022	Office Visit	Paid	$$$	$$$	$$$	$$$	$$$	$$$	$$$	A12
01/01/2022	Lab	Paid	$$$	$$$	$$$	$$$	$$$	$$$	$$$	B23
		Claim Total	$$$	$$$	$$$	$$$	$$$	$$$	$$$	

An EOB looks something like this, displaying valuable information about the healthcare services you received.

An Explanation of Benefits (EOB) is a statement generated by your health insurance company summarizing how it processed a claim from a doctor, hospital, or other medical provider.

Your carrier is required to provide you with EOBs. Most carriers will mail EOBs to your home, although you can opt out of receiving paper EOBs and instead sign-up for an online account with your carrier to access your documents digitally. If you aren't sure where to find your EOBs, please contact your carrier.

An EOB breaks down:

- What the provider charged
- What insurance paid
- What you must pay

An EOB is **not** a bill. It is, however, a valuable tool.

- Compare the EOB and your doctor's bill to make sure all info is correct.
- Check that you're being charged correctly.
- Note the amount you are expected to pay.

Questions? We're here to help!

877.626.6057 Monday-Friday, 6am-5pm PT/9am-5pm ET
clientsupport@nonstophealth.com

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