A Quick Guide To Your Plan

The PerfectHealth High Deductible Health Plan is simple and easy to use

- There are no referrals.
- You have the freedom to choose any provider at the time of service (only applicable on PPO plans).
- There are no PCP's to choose.
- Pre-certification is only required on inpatient hospital stays and within 30 days of pregnancy diagnosis.
- A Health Advocacy Program that can help you find hard to reach specialists.
- A maternity care program providing assistance, guidance and information throughout the course of pregnancy.
- A Medical Management Program to assist with difficult health issues.
- A discount prescription program that will enable participating Express Scripts pharmacies to determine your share of the claim based on your applicable deductible, at the point of sale.
- Easy access to our website to manage your medical plan and HSA bank account as well as provide you with direct links to our vendors.
- Access to a team of professional, courteous, knowledgeable Customer Service Representatives 8am-6pm Monday-Thursday; 8am-5pm Friday, to answer any question you may have.

You can find more detailed information regarding these programs in your Employee Welcome Kit.

What you can expect to receive from us

- An Employee Welcome Kit containing important information relating to your plan.
- A Booklet Certificate describing your benefits.
- An Identification Card which will provide you with your PerfectHealth plan and identification number; professional and hospital network; important telephone numbers and the address where to mail claims.
- An Express Scripts Identification Card which will be sent to you directly by Express Scripts. This ID card should be presented to your pharmacist at your first visit and will enable you to receive a discount on your prescriptions.
- A FirstHSA Bank Account kit (if you elected FirstHSA as your HSA Administrator). The kit will contain information on the HSA account. A debit card will also be sent to you. A PIN number for use with your debit card will be sent under separate cover for privacy reasons.
- A letter requesting proof of prior carrier coverage. Note: It is important to obtain and mail us the HIPAA notification from your prior carrier so that proper portability credit can be given to you as well as avoid any future claim processing delays.

HOW AND WHERE TO SUBMIT A CLAIM

1. When you visit your provider's office or hospital, you will need to present them with your Identification Card. The office will take a copy for their records.
2. Advise your provider of service that you have a High Deductible Health Plan with no co-pay. Your provider will submit the claim form to us. They will need to mail it to us at the address listed on the back of your Identification Card.
3. Upon receipt of the claim form from your provider of service, we will process it within 15 business days of receipt, provided all the needed information appears on the claim form (ex: Provider name; address; TIN #; Diagnosis Code; date of service, etc).
4. Once the claim form is processed by us, an Explanation of Benefits form (EOB) will be sent to you ***and*** to your provider of service detailing how the claim was processed. The EOB will reflect patient liability (amount you owe). This amount should be sent by you to your provider as soon as possible.
5. For prescription claims, as long as you utilize an Express Scripts participating pharmacy, the pharmacy will do the work for you and submit your RX claim electronically to us for proper claim adjudication. You will not receive an EOB on these RX claims, so be sure to save a copy of the drugstore receipt for future reference. Also, when using a participating Express Scripts pharmacy, medical claims and pharmacy information is shared between PerfectHealth and Express Scripts allowing both companies to maintain up-to-date, integrated deductible information. If you met your deductible and/or coinsurance (if applicable), you will not be required to pay for your prescription at the point of sale. To find a participating pharmacy near you, simply visit the Express Scripts website at www.express-scripts.com, or contact Express Scripts Customer Service Department at 1-866-374-5543. Remember that you can save up to 9% on brand name drugs and up to 25% on generic drugs just by using one of the over 44,500 Express Scripts pharmacies nationwide. Should you decide to use a non-participating Express Scripts pharmacy to get your medication, you will (1) not receive any discounts and (2) need to continue to submit your original RX claim receipts to us along with completing a Pharmacy Drug Claim form. Please contact us at 646-447-7077 for a supply of these forms.

Note:

When services are rendered by a participating in-network provider, the provider has agreed to accept a *discounted* rate from us. The provider has also agreed not to bill you the difference between the actual billed charges and the *discounted* amount. You are therefore only responsible for the *discounted* amount which will be applied to your deductible and coinsurance. Once your deductible and coinsurance limit are met, we will begin reimbursing you at 100% of the discounted amount.

Conversely, when services are rendered by a non-participating out of network provider (not available on EPO plans), we will determine the *allowed* amount based on a fee schedule established by using data developed by a premier health data research firm, Ingenix. This fee schedule is comparable to what we pay participating in-network providers. We will then apply the *allowed* amount to your deductible and coinsurance. Once your deductible and coinsurance limit are met, we will begin reimbursing you at 100% of the *allowed* amount. Keep in mind that non-participating out-of-network providers will often bill you a higher rate than what we *allow.* You will then be responsible for the difference in what PerfectHealth *allows* versus what the provider of service has actually billed you. Also, when you go to an out-of network provider, the provider may ask you to pay the billed charges at the time of service. If you are required to pay at the time of service, ask the provider for a detailed bill (which will include the diagnosis code; date of service; procedure code; providers name, address and Tax ID). You should then submit the original bill directly to us (keep a copy) at the address noted on the back of your ID Card.

Questions and Answers about Your Plan

Below are a few questions and answers about benefits under your plan. Please note that this list is not all inclusive. Please review your plan booklet for further plan details.

Q: How are pre-existing conditions covered under my plan?

A: This plan does contain a pre-existing condition limitation. A pre-existing condition will not be considered an eligible medical expense until an insured has been covered for 12 months in a row from the earliest of: (a) the date his or her insurance started under this Coverage; or (b) if there is a waiting period, the first day of the waiting period.

"Pre-Existing Condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the first day of Coverage, or, if there is a waiting period, the first day of the waiting period.

However, the length of time that a person is subject to this Pre-Existing condition exclusion will be reduced by the total amount of time the person was covered under one or more plans of Creditable Coverage that was not separated by a break in coverage of more than 63 days. The 63 break in coverage does not include any waiting periods satisfied under any prior Creditable Coverage.

If you are an employee covered under a large group plan, and, you were covered under your Employer's prior carrier, than your Employer most likely submitted proof of portability directly to PerfectHealth when your new plan was set up. However, if you were not on your Employer's prior carrier plan, or if you are covered under a small group plan, most likely you will be required to submit the HIPAA letter of portability that you will receive from your prior carrier directly to PerfectHealth in order to obtain credit.

Please refer to your plan booklet for additional information on the pre-existing condition exclusion or call our Customer Service Department at 646-447-7077 for assistance.

Q: I had an Emergency and was rushed to a hospital. I did not have time to evaluate whether the facility was in-network or not. If the facility was out-of-network, am I covered?

A: Emergency Care means the care provided to the insured who suffers an accidental injury or the sudden onset of a medical or behavioral condition with symptoms so severe, including severe pain, that without immediate medical attention a prudent layperson could reasonably expect that:

1. His or her health would be in serious jeopardy, or in the case of a behavioral condition, his or her health, or the health of others, would be in serious jeopardy; or
2. His or her bodily functions would be seriously impaired; or
3. A bodily organ or part would seriously dysfunction or be seriously damaged; or
4. He or she would suffer serious disfigurement.

If you are covered under an EPO Plan, benefits for Emergency Care will be paid as if the care was provided by a Network Provider. But, to continue benefits, the insured must obtain authorization within 48 hours (within 72 hours, if it starts between 5:00 P.M. on Friday and 8:00 A.M. on the next Monday), if admitted as an in-patient. (Please refer to your plan booklet for additional information on Emergency Care.)

If you are covered under a PPO Plan, benefits are determined based on whether you receive care from an in-network or out-of-network provider. The appropriate deductible and coinsurance (if applicable) will be applied accordingly. But, if you are admitted into the hospital, to continue benefits, the insured must obtain authorization within 48 hours (within 72 hours if admitted between 5:00 P.M. on Friday and 8:00 A.M. the following Monday).

Q: I am covered under a plan that has no out-of-network benefits. I was admitted to an in-network hospital; however, I found out that my anesthesiologist was out-of-network. I did not have a choice at the time. Am I covered?

A: Benefits for Hospital Based Services provided to an insured (who may have no out-of-network benefits) will be adjudicated as if services were provided by a Network Provider as long as services were received at a network facility.

Hospital Based Services means anesthesiology, assistant surgery, consultations and other professional services provided to an insured in connection with a hospital admission by a Network Provider.

However, you should be aware that although these claims will be considered an eligible expense, they will be limited to the in-network provider negotiated rates, and, the out-of-network provider may choose to balance bill you for the difference between the charges and the PerfectHealth allowed amount.

Q: I had multiple surgeries performed and noticed on my Explanation of Benefits (EOB) that the allowable expense was reduced on the secondary procedure. Why is this?

A: Multiple or bilateral surgical procedures means two or more procedures done at the same time. When they are done through the same incision, we pay benefits at 100% of the allowed amount for the most expensive procedure then being performed, less any applicable Deductible or Coinsurance. When they are done through different incisions, benefits are provided at 100% of the allowed amount for the most expensive procedure then being performed, and at 50% of the allowed amount for the less expensive procedures, less any applicable Deductible or Coinsurance.

Q: Are there any charges that my doctor might bill for that are considered incidental and not payable by PerfectHealth?

A: If a doctor bills for the Administration of an Immunization as well as the Immunization itself, PerfectHealth will deny the Administration of the Immunization charges as incidental and as being part of the Immunization charges. Additionally, if a doctor's office bills for an office visit and a surgery, PerfectHealth considers the office visit incidental and part of the surgery, and will deny the claim accordingly. These are two examples of PerfectHealth's claim policies. PerfectHealth also includes a list of Expenses that are Not Covered in your plan Booklet. You should always refer to your plan booklet for details.

Q: What is covered under the Adult Preventive Benefit?

A: Doctor's office visits for routine physical exams. This includes routine injections, inoculations, immunizations, routine x-rays, laboratory tests and multiphasic screening. These visits will be a Covered Expense when provided as appropriate to the insured's age, based on the recommendations of the U.S. Preventive Service Task Force for adults age 19 and older, as recommended by a doctor every 1 to 3 years.

We pay 100% of these Covered Expenses up to $250 per year. Then the benefits payable are subject to the applicable Deductible, Coinsurance, Coinsurance Limits and the Maximum Benefit as shown in your Certificate of Coverage.

Under the Adult Preventive Benefit we also cover routine mammography screening, annual OBGYN visit, annual colorectal cancer screening at age 50, bone mineral density tests, and prostate cancer screening. The benefits payable for these services are subject to the applicable Deductible, Coinsurance, Coinsurance Limits and the Maximum Benefit as shown in your Certificate of Coverage, and are not subject to the $250 per year maximum described above. Please refer to your plan booklet for complete details about these services.

Q: I received an Explanation of Benefits (EOB) from PerfectHealth asking me to submit accident details. Why does PerfectHealth need this information?

A: The claim information submitted by your provider of service indicated that some type of injury or accident may have occurred. PerfectHealth needs the details of the accident (how, when, and where) to determine if any other insurance, such as Automobile No-Fault or Workers' Compensation Insurance, was in place to determine benefits and liability.

Q: Is Speech Therapy a covered medical expense under my plan?

A: Speech Therapy is a covered expense following an injury or an illness such as a stroke. If treatment is due to a birth defect, then it will only be covered if surgery was performed to correct the birth defect. We do not cover Speech Therapy services for a child being treated for a learning disability, developmental delay, or other disabilities such as cerebral palsy and downs syndrome.

Q: How are Physical Therapy and Occupational Therapy services paid?

A: Physical Therapy and Occupational Therapy services are covered for four (4) weeks following an injury or surgery. If your doctor wishes to extend services beyond the first 4 weeks, PerfectHealth will require a letter of medical necessity, which should include the condition being treated, frequency of the visits and the duration of the extended therapy, and the complete treatment plan. This information is needed and must be reviewed and additional services approved before PerfectHealth will allow any services beyond the initial 4 week period of therapy.