U.S. Venture, Inc.

MEDICAL PLAN OPTIONS

Effective 1.1.2018

Summary of Benefits	Plan 1 Copay Plan		Plan 2 HSA - 2000	
	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider
Annual Deductible per Calendar Year	Non-network deductible applies to network deductible. Network deductible **DOES NOT** apply to non-network deductible.			
Single Coverage	$750	$4,500	$2,000	$4,000
Employee and 1 Dependent	$1,500	$9,000	$4,000 (1)	$8,000 (2)
Employee and 2+ Dependents	$2,250	$13,500	$4,000 (1)	$8,000 (2)
Coinsurance	80%	60%	90%	60%
Annual Out-of-Pocket Maximum	**Includes Deductible and Medical & Rx Copays**		**See Below**	
Single Coverage	$4,000	$13,500	$6,000	$12,000
Employee and 1 Dependent	$8,000	$27,000	$12,000 (1)	$24,000 (2)
Employee and 2+ Dependents	$12,000	$40,500	$12,000 (1)	$24,000 (2)
US Venture HSA Contributions	N/A		$500 Single Coverage; $1,000 EE+SP, EE+Child(ren) or Family Coverage	
2018 HSA Contribution Limits (Annual IRS Limits for 2018: *Combined Company & Employee Contributions)*	N/A		$3,450 Single; $6,850 EE+SP, EE+Child(ren), Family Coverage. An additional $1,000 can be contributed for each participant age 55 or older	
Physician Services				
Primary Care Physician Office Visits	$25 copay	60% after deductible	90% after deductible	60% after deductible
Specialist Office Visit	$50 copay			
Diagnostic Tests *(Performed in office and billed by a physician)*	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Fast-Care Clinics	$25 copay		90% after deductible	
Urgent Care	$50 copay		90% after deductible	
Emergency Room *(Facility & Physician Charges)*	$150 copay; subject to deductible & 80% coinsurance thereafter		90% after deductible	
Allergy Injections	$5 copay	60% after deductible	90% after deductible	60% after deductible
Allergy Serum	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Inpatient Physician Services	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Outpatient Physician Services	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Surgery *(Outpatient & Inpatient)*	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Radiologist, Pathologist and Anesthesiologist *(Benefits are paid at in network provider level if received at a network facility).*	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Chiropractic Care	$35 copay	60% after deductible	90% after deductible	60% after deductible
Preventive Care/Wellness Preventive / Routine Care Exams (Children & Adults) Lab/X-rays for Preventive / Routine Exams Routine Immunizations Pap Smear / PSA Test	100%	60% after deductible	100%	60% after deductible
Colonoscopy	1st colonoscopy in the plan year covered at 100%	60% after deductible	1st colonoscopy in the plan year covered at 100%	60% after deductible
Mammograms (includes 3D)	1st mammogram in the plan year covered at 100%	60% after deductible	100% if coded as preventive care/ wellness	60% after deductible
Ambulance	80% after deductible		90% after deductible	
Hospital Services				
Inpatient or Partial Hospitalization	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Outpatient Surgery - Facility	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Outpatient Non-Surgical *(Lab, x-ray, diagnostic tests and therapies)*	80% after deductible	60% after deductible	90% after deductible	60% after deductible

(1) **IMPORTANT HSA PLAN NOTICE (In-Network):** No individual family member's deductible is considered satisfied until the full family deductible has been met. However, no individual family member can exceed $6,850 in out-of-pocket expenses per year. The out-of-pocket limit for all family members combined remains at $12,000.

(2) **IMPORTANT HSA PLAN NOTICE (Out-of-Network):** No individual family member's deductible or out-of-pocket is considered satisfied until the full family deductible and out-of-pocket has been met.

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	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider
Extended Care / Skilled Nursing Facility	*60 days per confinement*		*60 days per confinement*	
	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Home Health Care Benefits	*120 visits per calendar year*		*120 visits per calendar year*	
	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Mental Health, Substance Abuse and Chemical			90% after deductible	60% after deductible
Inpatient or Partial Hospitalization	80% after deductible	60% after deductible		
Inpatient Professional Services	80% after deductible	60% after deductible		
Transitional Treatment	80% after deductible	60% after deductible		
Outpatient Treatment	80% after deductible	60% after deductible		
Office Visit Settings	$25 copay	60% after deductible		
Durable Medical Equipment	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Diabetic Education *(Professional Provider - i.e. Dietician/Nutritionist)*	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Therapy *(Includes occupational, physical and speech therapy)*	80% after deductible	60% after deductible	90% after deductible	60% after deductible
All Other Covered Benefits	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Transplant Services *(Consult UMR's Case Management Team prior to seeking transplant related services.)*	See plan document for details		See plan document for details	
Pharmacy Benefit	Participating Providers Only		Participating Providers Only	
Retail (31-Day Supply)			90% after deductible	
Tier 1 - Generics	$10			
Tier 2 - Brands / Preferred	$25			
Tier 3 - Brands / Non-Preferred	$50			
Retail (90-Day Supply)			90% after deductible	
Tier 1 - Generics	$30			
Tier 2 - Brands / Preferred	$75			
Tier 3 - Brands / Non-Preferred	$150			
Mail Order (90-Day Supply)			90% after deductible	
Tier 1 - Generics	$25			
Tier 2 - Brands / Preferred	$62.50			
Tier 3 - Brands / Non-Preferred	$125			
Specialty Medications	25% coinsurance		90% after deductible	
Preventive Medications Benefit ***(HSA Plan Only)***	N/A		***Refer to the Caremark Rx Preventive HSA Drug List***	
Generic			100% Coverage	
Brand without a Generic Equivalent			100% Coverage	
Brand with a Generic Equivalent			90% after deductible	
Contraceptives / Birth Control / Over-the-Counter (OTC) with a Prescription (Dispensed in an Office Visit or Pharmacy Setting)	100% coverage for Contraceptive Medications/Barrier Methods/Hormonal Methods & Emergency Contraceptives (100% Coverage for services rendered by In-Network Providers or Caremark Preferred Pharmacies Only). ***Refer to the Caremark ACA Preventive List for covered drugs.*** ***OTC with a prescription for Preventive Care drugs covered at 100%***			
Tobacco Cessation Drugs *(Rx or Over-the-Counter medications with a prescription)*	100% coverage (limited to 180 days per calendar year & members age 18 or over). ***Refer to the Caremark ACA Preventive List for covered drugs***			
Diabetic Supplies *(Participation in the UMR Diabetic Disease Management Program is not required)*	100% coverage when obtained through Mail Order Services. ***Caremark Rx Free Meter Program:*** Glucose meters provided at no cost to eligible members. For additional information, please contact the CVS Caremark Member Services Diabetic Meter Team at (888) 826-5645.		100% coverage. ***Caremark Rx Free Meter Program:*** Glucose meters provided at no cost to eligible members. For additional information, please contact the CVS Caremark Member Services Diabetic Meter Team at (888) 826-5645.	

Our standard of care and legal duty to the insured in providing insurance products and services is to follow the instructions of the insured in good faith.

This constitutes only a summary of the HSA plans involved. The actual contracts or plan documents must be consulted to determine the governing contractual provisions, limitations, or exclusions. There is no guarantee, expressed or implied by U.S. Venture, Inc., Associated Financial Group, or vendors of plan provisions or level of payments.

