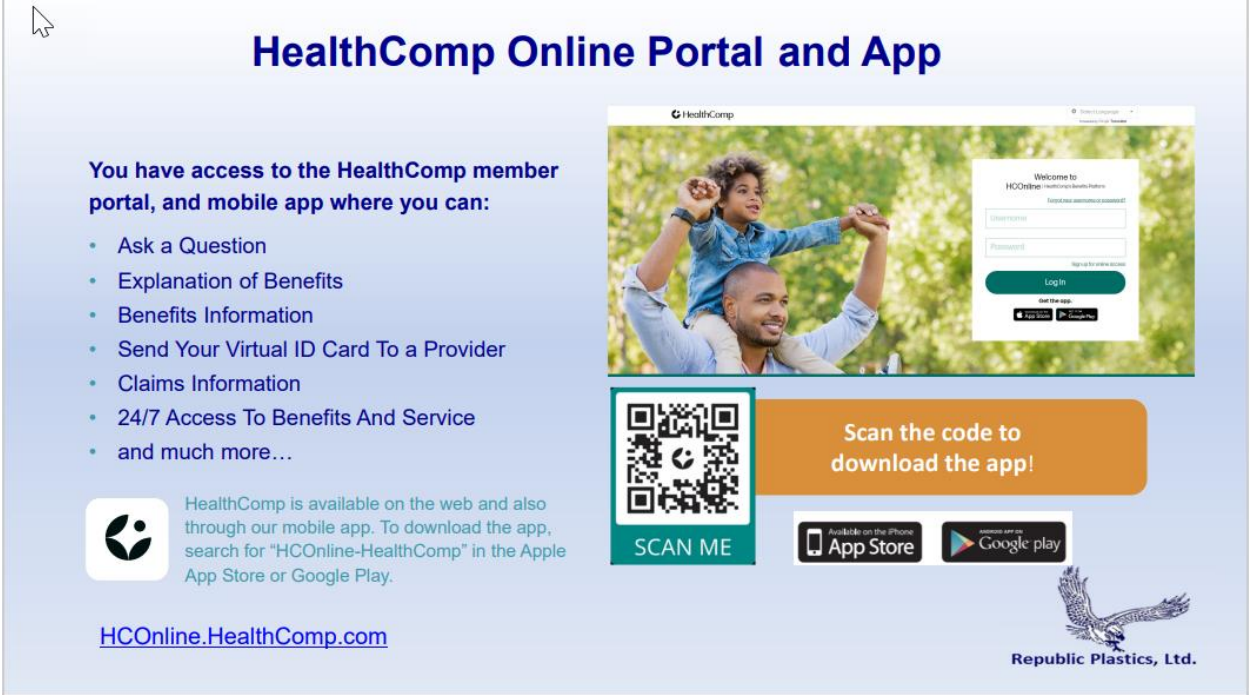
Medical Benefits - HealthComp

hconline.healthcomp.com 800-843-3831



Enrollment

New Hires: The first of the month following 30 days of employment. Enrollment is done by visiting ukg.republicplastics.com and going to Myself and then Life Events. Choose the Life Event "I'm a new hire" and follow the instructions provided. You will need to have entered at least one beneficiary prior to completing the enrollment process. This is done under Contacts in UKG. Contacts is also where you would add any dependents before you do your life event enrollment. You will need the Beneficiary legal name and if possible, DOB and SS# would be very helpful. To add dependents, you will need legal name, DOB, SS#, gender and relationship to you.

Open Enrollment: Happens once a year (March-April) with an effective date of May 1.

Qualifying Event: This is your life event and must be completed within 30days of the event date. Life events are events such as marriage, divorce, death, birth of a child, adoption, spouse and/or child loses coverage elsewhere or your spouse's employer's open enrollment. Proof of event must be provided to the company within 30 days of the life event.

Medical Plans: The Company offers two Medical Plans. These are referred to as the 5000 Deductible Plan and the 2500 Deductible Plan.

5000 Deductible Plan

Medical Benefits – HealthComp (formerly BAS)		
$5,000 Deductible Medical Plan		
Lifetime Maximum	Unlimited	
Calendar Year Deductible	Multiplan Provider	Other Provider
Individual	$5,000	$10,000
Family limit	$10,000	$20,000
Coinsurance	80%	60%
Out-of-Pocket Maximum (includes deductible)		
Individual	$5,600	$20,000
Family limit	$11,200	$40,000
Hospital Services		
Inpatient	80% of allowable amt.	60% after ded.
Outpatient Surgery	80% after ded.	60% after ded.
Primary Care Office Visit	$35 copay	60% after ded.
Specialist Office Visit	$45 copay	60% after ded.
Urgent Care Visit	$55 copay	60% after ded.
Preventive Care Services	100%	60% after ded.
Emergency Room - Accident	$150 copay; then 80% ded waived	$150 copay; then 80% ded waived
Skilled Nursing Facility *(25 days per cal year)*	80% after ded.	60% after ded.
Home Health Care *(60 visits per cal year)*	80% after ded.	60% after ded.
Mental & Nervous/Substance Abuse		
Hospital Inpatient	80% of allowable amt.	60% after ded.
Outpatient	$35 Copay	60% after ded.
Prescription Drug Program		
Prescription Drugs Retail *(up to 30-day supply)*	CVSCaremark	Other Provider
Preferred Generic	$20	60% after $20 copay
Preferred Brand	$40	60% after $40 copay
Non-Preferred	$60	60% after $60 copay
Mail Order Drugs (*90-day supply)*	CVSCaremark	Other Provider
Preferred Generic	$60	
Preferred Brand	$120	Not Covered
Non-Preferred	$180	

2500 Deductible Plan

Medical Benefits – HealthComp (formerly BAS)		
$2,500 Deductible Medical Plan		
Lifetime Maximum	Unlimited	
Calendar Year Deductible	Multiplan Provider	Other Provider
Individual	$2,500	$7,500
Family limit	$5,000	$15,000
Coinsurance	90%	70%
Out-of-Pocket Maximum (includes deductible)		
Individual	$5,000	$22,500
Family limit	$10,000	$45,000
Hospital Services		
Inpatient	90% of allowable amt.	70% after ded.
Outpatient Surgery	90% after ded.	70% after ded.
Primary Care Office Visit	$25 copay	70% after ded.
Specialist Office Visit	$40 copay	70% after ded.
Urgent Care Visit	$50 copay	70% after ded.
Preventive Care Services	100%	70% after ded.
Emergency Room - Accident	$150 copay; then 90% ded waived	$150 copay; then 90% ded waived
Skilled Nursing Facility *(25 days per cal year)*	90% after ded.	70% after ded.
Home Health Care *(60 visits per cal year)*	90% after ded.	70% after ded.
Mental & Nervous/Substance Abuse		
Hospital Inpatient	90% of allowable amt.	70% after ded.
Outpatient	$25 Copay	70% after ded.
Prescription Drug Program		
Prescription Drugs Retail *(up to 30-day supply)*	CVSCaremark	Other Provider
Preferred Generic	$15	70% after $15 copay
Preferred Brand	$35	70% after $35 copay
Non-Preferred	$55	70% after $55 copay
Mail Order Drugs (*90-day supply)*	CVSCaremark	Other Provider
Preferred Generic	$45	
Preferred Brand	$105	Not Covered
Non-Preferred	$165	

Please note that plans are subject to change.

HELPFUL DEFINITIONS

Calendar Year – January 1st through December 31st of each year.

Coinsurance – The percent of eligible charges that the plan pays.

Copayment (Copay) – The amount paid by a covered person to a network provider at the time services are rendered. Copayments for covered services are not applied to your deductible.

Deductible – The amount you pay each calendar year before the plan begins to pay for certain covered health care expenses.

Guarantee Issue – The amount of coverage pre-approved by the Life Insurance Company regardless of health status.

Medical Emergency – A sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or body part.

Network Benefits – The benefits applicable for the covered services of a network provider.

Non-Network Benefits – The benefits applicable for the covered services of a non-network provider.

Open Enrollment – The period during which existing employees and their dependents are given the opportunity to enroll in or change their current elections.

Out-of-Pocket Maximum – The most a covered person can pay in coinsurance in a calendar year for covered health care expenses (excluding reductions for provider contracts and usual and customary guidelines and co-pays).

Plan Year – Benefits runs May 1 through April 30. Annual Deductibles run calendar year, except for dental and vision those are plan year.

Preferred Provider Organization (PPO) – A network of health care providers contracted to provide medical services to covered employees and dependents at negotiated rates. You may seek care from either a net- work or non-network provider, but network care is covered at a higher benefit level and the employee is re- sponsible for a greater portion of the cost when using a non-network provider.

Usual and Customary Rates – Non-network health plan expenses are considered for reimbursement at usual and customary (U&C) rates. U&C rates are determined to be the prevailing charge made for a service by a similar provider in the same geographic area. Charges above U&C are not covered by the plan and are the responsibility of the participant.

How to use my benefits?

KNOW WHERE TO GO

Type	Appropriate for	Access	Cost
First Stop Health Telemedicine/Online Visit Virtual Primary Care	Virtual Primary Care, Urgent Care and Mental Health – includes treatment for minor illnesses and conditions (colds, allergy, rash), mental health issues	24/7	FREE
Office visit	Preventive and routine medical care (illness, injuries, physical and mental health)	Office Hours	$$
Urgent care, Walk-in clinic	Non-life-threatening conditions requiring prompt attention (cuts, sprains, flu)	Vary, up to 24/7	$$
Emergency room	Life-threatening conditions requiring immediate medical expertise (heart attack, stroke, difficulty breathing)	24/7	$$$$

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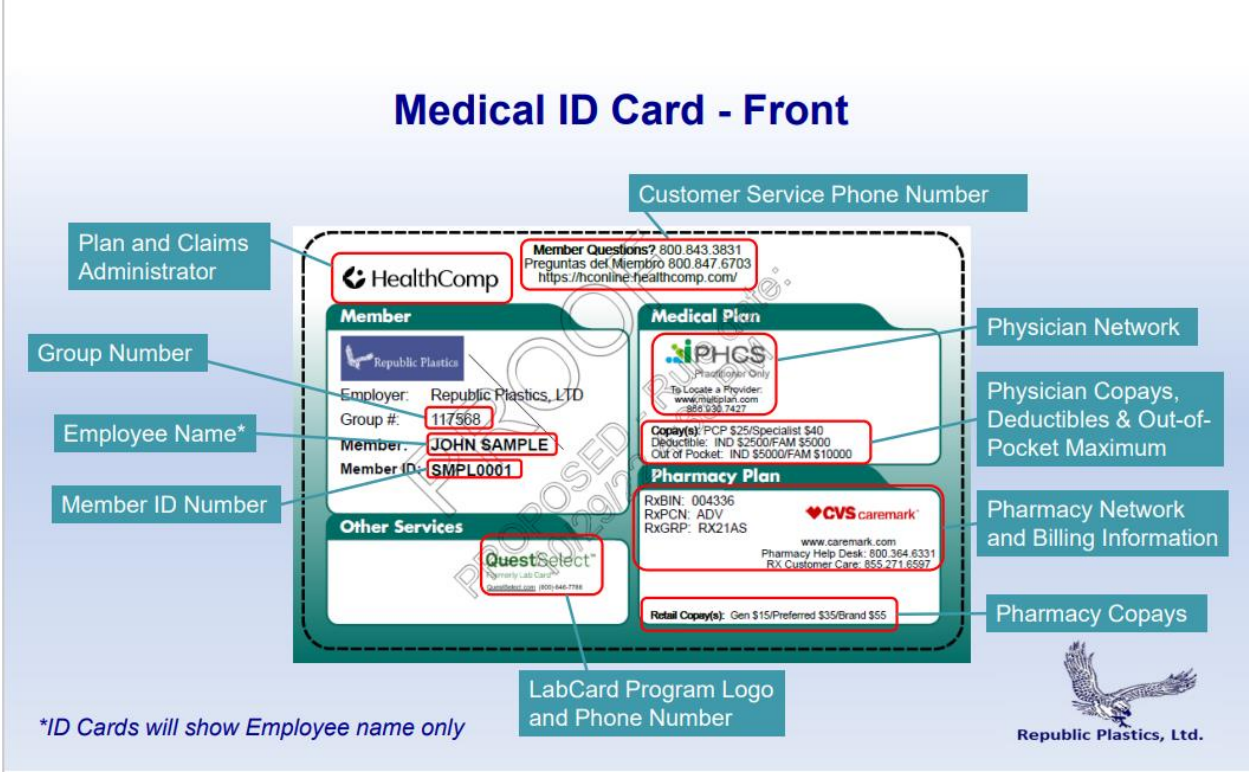
If you need emergency care

- In a life-threatening situation (heart attack, stroke, difficulty breathing), get care right away!
- Call HealthComp @ 1.800.843.3831 **and they will help you find a PHCS provider or another provider in your area.**
- **Give the facility your insurance card. If you receive a balance bill or other correspondence from the facility call HealthComp @ 1.800.843.3831.**

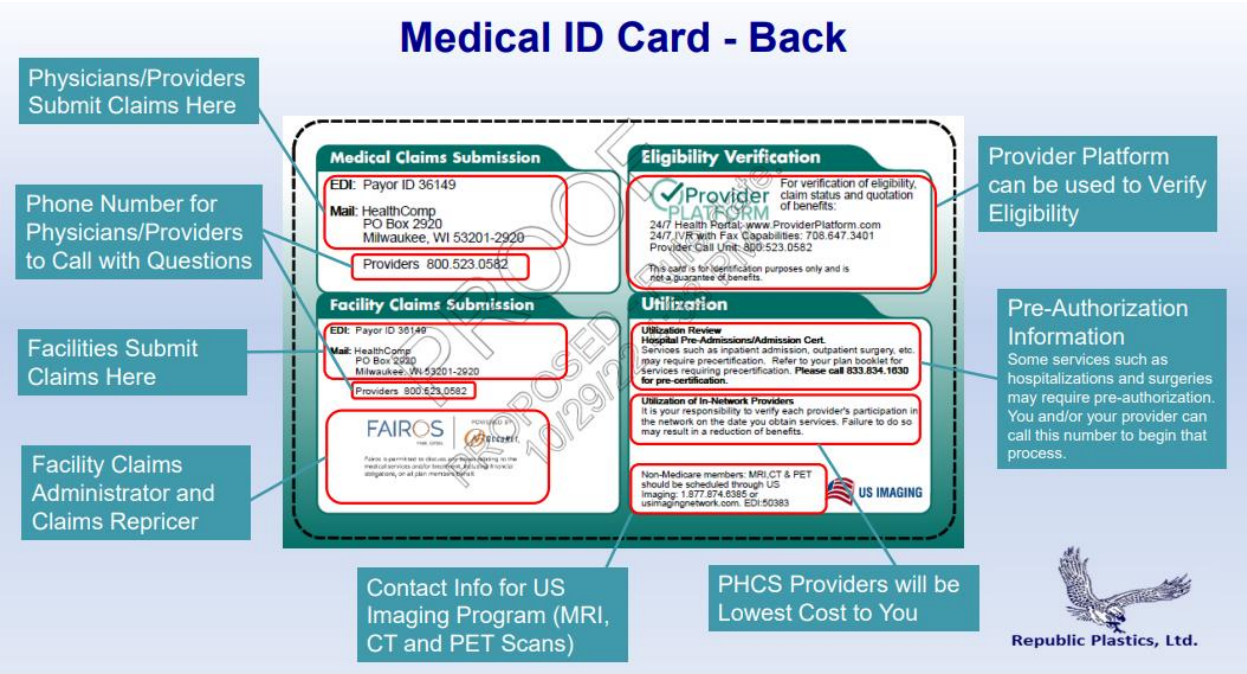
No Cost and Lowest Cost Member Services

- **First Stop Health: Virtual Primary Care, Virtual Urgent Care, Virtual Mental Health:** Appointments with a First Stop Health doctor over the phone, through the mobile app or online are covered 100% by the plan – no cost to you.
- **Lab Card:** If you schedule your outpatient lab testing through the Lab Card program, they will be covered 100% by the plan – no cost to you. This program utilizes both Quest Diagnostics and LabCorp labs.
- **US Imaging:** If you schedule your outpatient MRI, CT or PET Scan through the US Imaging program, they will be covered 100% by the plan – no cost to you.
- **PHCS:** If you utilizes physician services that part of the PHCS network, you will not be balance billed outside of your patient responsibility – this is your lowest cost option to see a doctor.

Medical Card: You can order / view your medical card by logging in to HealthComp and view your card and/or request one be mailed out to you.



The back of your card is mainly for the providers.



Need to see a Provider, you have options.

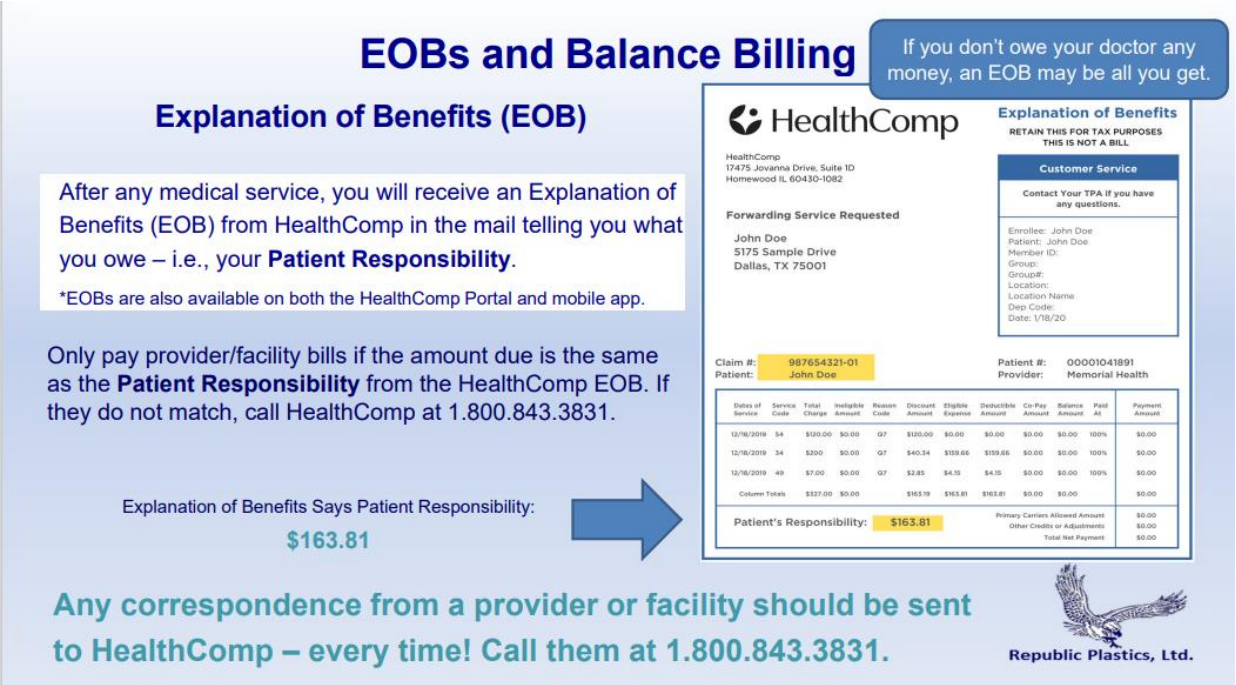
Option 1 – FREE - First Stop Health Virtual Care. Primary Care, Urgent Care, Mental Health appointments with a First Stop Health doctor over the phone, through the mobile app or online are covered at 100% by the plan – no cost to you.

O**ption 2 –** Prefer to see a physician in their office and pay the co-pay? Look for a provider near you by going to HealthComp's website and search for a provider near you.

What is Explanation of Benefits (EOB)?

An explanation of benefits (EOB) is a document provided to you by your insurance company after you had a healthcare service for which a claim was submitted to your insurance plan. Your EOB gives you information about how an insurance claim from a medical provider (such as a doctor, hospital, or lab) was paid on your behalf and what if anything you may owe. It's very important that you always review these EOB's once you receive them and before you pay any medical bills from the provider to make sure that you owe them money.

If your EOB shows you owe nothing or you do owe and you receive a bill from the provider stating you owe more than what the EOB states, this is referred to as a balance bill. You must call HealthComp and let them know and they will reach out to the provider for you. Only pay the amount that the EOB is stating. If you are not sure, reach out to HealthComp.



EOBs and Balance Billing

Balance Bill

When the provider doesn't agree with the amount paid by the plan for services and sends you a bill for the difference.

- A balance bill will never have the phrase "Balance Bill" on it.
- Each statement will look different. Typically, they will include the logo of the providers office or facility where services were performed.
- The statement will specify an amount for you to pay – before paying, compare that amount to the Patient Responsibility listed on your HealthComp EOB.
  - If the amounts match, pay the provider/facility bill.
  - If the amounts do not match, call HealthComp.
  - Unsure or if the statement is confusing, call HealthComp.

Any cost related correspondence from a provider or facility should be sent to HealthComp – every time! Call them at 1.800.843.3831.

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EOBs and Balance Billing

What If I Get A Bill For A Different Amount Than The EOB?

- You only need to pay your share of the cost (deductible, co-payment, co-insurance) of eligible expenses as indicated on the Explanation of Benefits (EOB) as Patient Responsibility. Once this is paid to your provider, you do not owe them any more money.
- Call HealthComp @ 1.800.843.3831 – between 7am-8pm CST – if you get a bill from your provider that DOES NOT match your EOB Patient Responsibility.

What does a balance bill look like?

- It's not your explanation of benefits (EOB)
- The amount due is more than what your EOB said you owe
- The balance bill will likely be sent from the provider
- It won't say "Balance Bill"

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EOBs and Balance Billing

FAIROS
FAIR. OPEN.

Balance Bill Process

- Call HealthComp @ 1.800.843.3831 – between 7am-8pm CST – if you get a bill from your provider that does not match your EOB or any other correspondence.
- HealthComp will connect you with the Fairos Advocacy Team and your dedicated Fairos Advocate.
- Your Fairos Advocate will explain the process and act as your guide for each step.
    - **Important**: Call HealthComp as soon as you receive the balance bill. This is important to protect your rights under Fair Credit Billing Laws.
    - **Do** pay the provider or facility the amount listed on your EOB. This will help the balance bill process smoothly.
- Fairos will dispute any amount that is not correct and will manage the process until the balance bill is resolved.
    - Fairos will handle communication between your doctor, the facility and anyone else involved in the process.
- Your dedicated Fairos Advocate will keep you updated along the way. You will know their name and have direct access to them via phone & email. Additionally, you will be able to access updates on the easy to use Fairos portal.