Nagarro, Inc.
HDHP Plan
Effective 1/1/21

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM CALENDAR YEAR AMOUNT	UNLIMITED	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$3,000	$5,400
Per Family Unit	$6,000	$10,800
The In-Network Deductible and Non-Netork Deductible are separate.		
A person with individual coverage must satisfy the per person Deductible before Coinsurance applies to that person. For those with family coverage, each person must satisfy the per person Deductible before Coinsurance applies to that person. The Deductible will not exceed the per family Deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (Includes Deductible)		
Per Covered Person	$3,000	$8,400
Per Family Unit	$6,000	$16,800
The In-Network and Non-Network Maximum Out-of-Pocket Expenses are separate.		
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Amounts not covered by the Plan Amounts over Usual and Reasonable charge Cost containment penalties		
COVERED CHARGES		
Hospital Services		
Room and Board	100% after deductible	70% after deductible
Intensive Care Unit	100% after deductible	70% after deductible
Emergency Room Visit	$100% after deductible	
Physical Rehabilitation Facility	100% after deductible	70% after deductible
Newborn Nursery	100% after deductible	70% after deductible
Outpatient Care	100% after deductible	70% after deductible
Skilled Nursing Facility - Limited to 81 days per Calendar Year.	100% after deductible	70% after deductible
Physician Office Services		
Physician Office visits	100% after deductible	70% after deductible
Allergy serum & testing	100% after deductible	70% after deductible
Injections	100% after deductible	70% after deductible
Office Surgery	100% after deductible	70% after deductible
Laboratory and Diagnostic Testing	100% after deductible	70% after deductible
Pregnancy, including Dependent Daughter-Initial visit only	100% after deductible	70% after deductible
Physician Services at a Facility other than Office		
Emergency Room Physician	100% after deductible	
Inpatient Services	100% after deductible	70% after deductible
Outpatient Services	100% after deductible	70% after deductible
Routine Well Newborn	100% after deductible	70% after deductible
Urgent Care Facility	100% after deductible	70% after deductible
Laboratory and X-ray Services		
Inpatient	100% after deductible	70% after deductible
Outpatient	100% after deductible	70% after deductible
Independent Laboratory/X-ray	100% after deductible	70% after deductible
High Tech Imaging, including but not limited to CT, MRI, PET and SPECT scans	100% after deductible	70% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Acupuncture, Massage Therapy, Naturopathic Services and Nutritional Counseling- Limited to 12 visits per Calendar Year, except Nutritional Counseling is limited to 3 visits while covered under this plan	100% after deductible	70% after deductible
Ambulance Service	100% after deductible	
Chemotherapy/Radiation Therapy	100% after deductible	70% after deductible
Chronic Pain Treatment - Limited to 10 visits per Calendar Year.	100% after deductible	70% after deductible
Testing for the 2019 Novel Coronavirus (COVID-19)	100% Deductible waived	100% Deductible waived
Charges related to the testing for the 2019 Novel Coronavirus (COVID-19)	100% Deductible waived	100% Deductible waived
The above benefits are specific to Diagnosis of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.		
Durable Medical Equipment (covered up to purchase price)	100% after deductible	70% after deductible
Home Health Care- Limited to 100 days per Calendar Year.	100% after deductible	70% after deductible
Hospice Care -Limited to 6 months while covered under this Plan.	100% after deductible	70% after deductible
Occupational Therapy- Limited to 60 visits per Calendar Year.	100% after deductible	70% after deductible
Organ & Tissue Transplants **Transportation, Lodging and Meals of Companion** -Transportation of companion limited to $1,000 per approved transplant procedure, lodging and meals of companion limited to $250 per day while recipient is hospital confined and $10,000 while covered under the Plan.	100% after deductible 100% after deductible. (Not covered if not in designated transplant facility)	70% after deductible Not Covered
Orthotics	100% after deductible	70% after deductible
Physical Therapy- Limited to 60 visits per Calendary Year.	100% after deductible	70% after deductible
Prosthetics	100% after deductible	70% after deductible
Renal Dialysis	100% after deductible	70% after deductible
Speech Therapy – Limited to 60 visits per Calendar Year.	100% after deductible	70% after deductible
Spinal Manipulation Chiropractic -Limited to 30 visits per Calendar Year.	100% after deductible	70% after deductible
Tobacco Cessation – limited to 4 counseling sessions per Calendar Year	100% deductible waived	70% after deductible
Mental Health & Substance Abuse Care		
Inpatient	100% after deductible; the semiprivate room rate applies	70% after deductible; the semiprivate room rate applies
Outpatient/Partial Hospitalization	100% after deductible	70% after deductible
Office Visit	100% after deductible	70% after deductible
Preventive Care		
Routine Well Adult Care	100% deductible waived	70% after deductible
Routine Well Child Care	100% deductible waived	70% after deductible
All Other Covered Services	100% after deductible	70% after deductible

PRESCRIPTION DRUG BENEFIT

NOTE: Prescription Drugs are subject to the Calendar Year Medical deductible and Out-of-Pocket Maximum.

Note: If a member purchases a Brand Name drug when a Generic is available, the Covered Person will pay the difference in the cost of the Brand Name and Generic in addition to the copayment, unless the Physician instructs to dispense Brand Name only.

Retail Prescription Drug Option – up to a 30-day supply

Generic Drugs ..... Deductible then 100%

Preferred Brand Name Drugs..... Deductible then 100%

Non-Preferred Brand Name Drugs ..... Deductible then 100%

Mail Order Prescription Drug Option – up to a 90-day supply

Generic Drugs ..... Deductible then 100%

Preferred Brand Name Drugs..... Deductible then 100%

Non-Preferred Brand Name Drugs ..... Deductible then 100%

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Vision Care Benefit Schedule

Maximum Benefit per Covered Person per Calendar Year..... $250
(Does not apply to annual routine eye exam or contact exam and refraction)

NOTE: The $250 Calendar Year Benefit can be used for any one or combination of materials shown below.

Routine Eye Exam and Refraction .... 100% after $25 copay

Contact Lens Exam (fitting and evaluation) .... 100% after $60 copay

Frames..... .....100% to a maximum of $140

Lenses..... .....100% to a maximum of $130

Contact Lenses..... .....100% to a maximum of $130

Extra Material Enhancements ....100% to Calendar Year Maximum

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Dental Schedule of Benefits

DENTAL BENEFITS

Calendar Year deductible, per person	$50
per Family Unit	$150

The deductible applies to these Classes of Service:

Class B Services - Basic

Class C Services – Major

Class D Services – Orthodontia

Dental Percentage Payable

Class A Services - Preventive	100%
Class B Services - Basic	80%
Class C Services - Major	50%
Class D Services - Orthodontic (for dependent children to age 19)	50%

Maximum Benefit Amount

For Class B, and C Services:

Per person per Calendar Year	$1,500

For Class D-Orthodontia:

Lifetime maximum	$1,500

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each Calendar Year.

(2) One bitewing x-ray series every 24 months.

(3) One full mouth x-ray every 36 months.

(4) X-rays

(5) One fluoride treatment for covered Dependent children under age 19 each Calendar Year.

(6) Emergency palliative treatment for pain.

(7) Sealants on the occlusal surface of a permanent posterior tooth for Dependent up to age 16, once per tooth.

Class B Services:
Basic Dental Procedures

(1) Oral Surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(2) Periodontics (gum treatments), both surgical and non-surgical.

(3) Endodontics (root canals).

(4) Extractions. This service includes local anesthesia and routine post-operative care.

(5) Space maintainers for covered Dependent children under age 14 to replace primary teeth.

(6) Recementing bridges, crowns or inlays.

(7) Repair of crowns, inlays, onlays, bridgework and removable dentures.

(8) Fillings, other than gold.

(9) General anesthetics, upon demonstration of Medical Necessity.

Class C Services:
Major Dental Procedures

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Installation of crowns.

(3) Installing precision attachments for removable dentures.

(4) Addition of clasp or rest to existing partial removable dentures.

(5) Initial installation of fixed bridgework to replace one or more natural teeth.

(6) Rebasing or relining of removable dentures.

(7) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

(b) The replacement or addition of teethe is required because of one or more natural teeth being extracted after the person is covered under these benefits.

(8) Implants, including any appliances and/or crowns and the surgical insertion or removal of an implant.

Class D Services:
Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment we recommend that a predetermination of benefits be submitted for all anticipated work that is considered to be expensive by the Covered Person. A predetermination of benefits is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Corporate Benefits Service, Inc
PO Box 211778
Eagan, MN 55121
800-277-9476

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(6) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(7) **No listing.** Services which are not included in the list of covered dental services.

(8) **Occlusal guards.**

(9) **Personalization.** Personalization of dentures.

(10) **Replacement.** Replacement of lost or stolen appliances.

(11) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.