Verification of Benefits

DISCLAIMER: PLEASE READ CAREFULLY

Verification of Benefits and/or pre-certification is not a guarantee of payment. All expenses are subject to eligibility requirements and plan exclusions. All coverage must be verified through the Employer. The provisions shown are merely summarized. The Plan will not honor or recognize any agreement between a Participant and any third party, including a medical provider; eligibility, benefits, and all other claim determinations will be made in accordance with the terms of the Plan Document only. For full details, consult the Employee's Schedule of Benefits and Plan Document.

		Current Benefit Plan Coverage Period
CTCO Benefits Services, LLC 6342	**(6342MEDERPR)**	**01/01/25-12/31/25**
Precertification, Medical Helpline,call,	**844.720.2806** **(see addtl info below)**	**www.medhelpline.com**
Eligibility, Benefits, Claims Status, call	**318-747-0577**	**www.90degreebenefits.com**

Benefit Description	**Network**	**Non Network**
Maximum Lifetime Benefit	Unlimited	Unlimited
Deductible per Covered Person per CY	$750	$1,500
Deductible per Family Unit per CY	$2,250	$4,500
Deductible Carryover per Covered Person only	Yes	Yes
Out of Pocket per Covered Person per CY excl ded	$2,000	$4,000
Out of Pocket per Family per CY excl ded	$4,000	$8,000
Copay Physician Office Visit	$30	N/A
Copay Urgent Care Center	$75	N/A
Copay Emergency Room - Illness	$200 waived if admitted	$200 waived if admitted
Copay Emergency Room - Accident	N/A	N/A
Supplementary Accident Benefit	100% $350 maximum	100% $350 maximum
Office Visits	100% after copay	50% after ded
Urgent Care	100% after copay	50% after ded
Room & Board	70% after ded	50% after ded
ICU	70% after ded	50% after ded
Emergency Room - Illness	70% after copay & ded	50% after copay & ded
Emergency Room - Accident	70% after ded	50% after ded
Skilled Nursing Facility	70% after ded	50% after ded
Advanced Imaging - CT, MRA, MRI, PET, SPECT	70% after ded	50% after ded
Home Health	70% after ded	50% after ded
Hospice	70% after ded	50% after ded
Occupational Therapy	70% after ded	50% after ded
Speech Therapy	70% after ded	50% after ded
Physical Therapy	70% after ded	50% after ded
Durable Medical Equipment	70% after ded	50% after ded
Hearing Aids	70% after ded $4,000 per ear/36 mths	50% after ded $4,000 per ear/36 mths
Spinal Manipulation Chiropractic	100% after copay	50% after ded
Mental Disorders I/P	70% after ded	50% after ded
Mental Disorders O/P	70% after ded	50% after ded

Mental Disorders Office Visit	100% after $30 copay	50% after ded
Substance Abuse I/P	70% after ded	50% after ded
Substance Abuse O/P	70% after ded	50% after ded
Substance Abuse Office Visit	100% after $30 copay	50% after ded
Preventative Care - MyHealth Scheduled Preventative Care	100%	100%
Preventative Care - Other Preventative Care	100%	100%
Preventative Care - Mayo Clinic Executive Wellness Program	100%	N/A
Organ Transplant	70% after ded	50% after ded
Dialysis	70% after ded	50% after ded
Pregnancy & Initial Hosp Newborn Care	70% after ded	50% after ded

Claim Filing Deadline is twelve (12) months from the date of service.

Precertification: Penalty for failure to precertify is the benefit payment will be reduced by $1,000 per inpatient confinement. Failure to precertify may result in a reduction of benefits received from the Plan.

Inpatient services and Transplant procedures require precertification, and failure to do so will result in precertification penalties. There are also certain Outpatient services that require precertification: Outpatient Surgery, Outpatient Diagnostic Services, Outpatient Continuing Care, Outpatient Psychiatric and Substance Abuse Services. For a more comprehensive outline of these services, contact our Customer Service Department at 318.747.0577. Observation lasting over 23 hours will be considered inpatient and will require precertification.

Inpatient rehabilitation following Hospital confinement must be certified at least 2 days prior to transfer or **NO BENEFITS ARE PAYABLE.** Also, if a Covered Person stays in the Hospital longer than originally certified, and the extended stay is not certified, **NO BENEFITS ARE PAYABLE** for the remainder of the Hospital stay.

Networks:

First Choice Verity & Verity Health	**electronic payor # 72091**		**www.verityhealth.com**
PHCS	**electronic payor # 72091**	**1.800.922.4362**	**www.multiplan.com**

Deductible: Network and Non Network deductibles are a **combined** maximum. Amounts satisfied and applied to Network deductible apply to the Non Network deductible and vice versa.

Deductible is waived for Supplementary Accident Charges and Preventative Care.

Out of Pocket: Network and Non Network out of pocket amounts are a **combined** maximum. Amounts satisfied and applied to Network out of pocket apply to the Non Network out of pocket and vice versa.

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. Deductibles, cost containment penalties, and benefits already covered at 100% do not apply toward the out of pocket maximum and are never paid at 100%.

Copays: The Physician and Urgent Care Center visit copay is for all services rendered in physician office or urgent care center for each day of service, including diagnostic radiology and laboratory ordered by the network physician at an outside facility. Advanced imaging is subject to deductible and coinsurance. The Emergency Room copay (illness) is waived if admitted.

Supplementary Accident Benefit: Treatment must commence within 72 hours and be rendered within 90 days of the date of the accident.

ICU: Weekend Admissions are not allowed on Friday, Saturday or Sunday unless emergency admission or surgery is scheduled within 24 hours of admission.

Hospice: Life expectancy of six months or less.

Occupational Therapy: Covered when under the direct supervision of a licensed therapist or certified althleic trainer in a home setting or at a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free standing outpatient facility. A written presciption for therapy is not required. Precertification is required after 24 visits.

Speech Therapy: Covered when under the direct supervision of a physician for restorative speech therapy for speech loss or impairment due to an illness or injury, or due to surgery performed due to an illness or injury, other than a learning or mental disorder. A written presciption for therapy is required including the frequency and duration. Precertification is required after 24 visits.

Physical Therapy: Covered when under the direct supervision of a licensed therapist or certified althleic trainer in a home setting or at a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free standing outpatient facility. A written presciption for therapy is not required. Precertification is required after 24 visits.

Durable Medical Equipment: Required for therapeutic use; rental, repair or purchase of this equipment, whichever

Preventative Care - Routine Well Care: Includes office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical exam, x-rays, colonoscopy, diagnostic and laboratory tests, immunizations/flu shots and routine well child care. Also covered under this benefit is preventative care as required by law.

Preventative Care - Mayo Executive Wellness Program: Authorization must be obtained from 90 Degree Benefit prior to incurring any charges.

Organ Transplant: Services must be precertified and Second Surgical Opinion is required.

Dialysis: All providers including Network Providers are considered to be Non Network unless there is a rate contracted through an 90 Degree Benefits approved repricing source.

Pregnancy & Initial Hospital Newborn Care: Routine well newborn care in hospital is covered as part of the mother's maternity claim. Global Billing services not subject to copay. Dependent daughters not covered.

Impacted Teeth: Services rendered in physician office subject to copay if applicable.

Foot Disorders: Covered only for open cutting operations, removal of nail or nail root. No coverage for trimming corns/callouses, orthopedic shoes or other devices for the support of the feet.

Not Covered: TMJ, Infertility, Obesity, Learning Disabilities and Behavior Disorders.