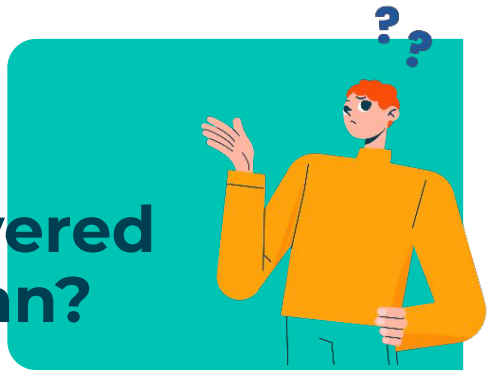
nonstop HEALTH



In-Network Providers and Covered Services...What Does This Mean?

The Nonstop Health program only works with in-network providers/facilities and covered services and prescriptions. But what do these terms mean? This document will break down some of the most common terms associated with Nonstop Health and provide tips and tricks for ensuring you stay in compliance with our program.

Key Terms

Let's start by reviewing key terms that you'll read, see or hear about with Nonstop Health.

In-network: Providers that are in-network are those that have a contract with your carrier, and have set up a pre-negotiated rate for different services. As such, the provider can only charge the carrier – and you – a set price for the services you receive. This results in lower costs for you, as in-network providers almost always charge less than an out-of-network provider.

Out-of-network: An out-of-network provider has not signed a contract with your carrier, and therefore they can set whatever price they would like for healthcare services. Some carriers and plans allow you to access out-of-network services, but those services will cost you more and are covered differently than in-network care. Other carriers and plans do not cover out-of-network services at all. It is important to research if and how your carrier covers out-of-network services under your plan, and how the higher prices will impact you.

Covered services: A covered service is one that your carrier has agreed to pay for under your medical plan. Not all services are covered by every plan, so before receiving a new service please check with your carrier first. Your carrier may have a cost or visit limit for specified services, or other limitations.

Covered prescriptions: Your carrier will set a "formulary" or drug list at the beginning of each plan year, which lists what prescriptions will be covered under your medical plan. Just because a doctor prescribes you a medication doesn't mean it's automatically covered by your carrier, so before filing and paying for a new prescription, be sure to call your carrier or ask your pharmacist if it's covered. If it's not covered, you can ask your pharmacist for an alternative medication that is covered in the formulary list. If you want to go with the alternative, please discuss the change with your doctor and they can re-write your prescription.

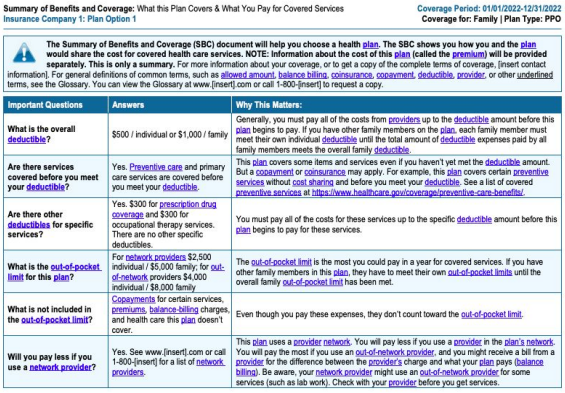
Carrier approved: A carrier-approved service or prescription is one that your carrier has agreed to cover as part of your underlying medical plan. This includes covered services and prescriptions. However, it also can indicate that your carrier has given you explicit/written permission to see an out-of-network provider for services and those costs will be considered in-network and covered under your plan.

QUICK TIP!

For an easy way to find out if a provider is in-network or a service or prescription is covered by your medical plan, call/email your medical carrier or sign up for an online account with them!

What is a Summary of Benefits and Coverage (SBC)?

An SBC is one of the quickest ways to find out what your deductible and out-of-pocket maximum is, what services are covered under your medical plan, and any copays or coinsurance you'll be required to pay at the time of service. You can find your medical plan SBC on the Nonstop Exchange member portal (or mobile app) under Employee Documents.



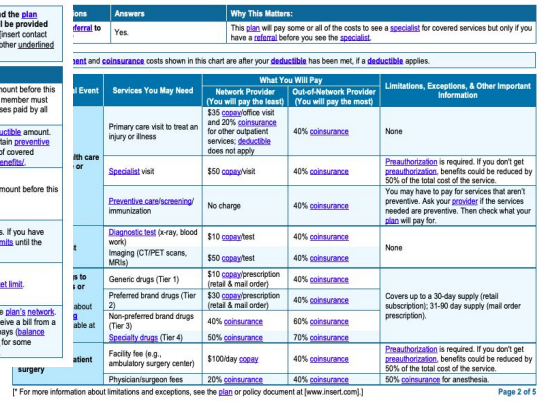
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2022-12/31/2022
Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 / individual or $1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

The first page of your SBC will show you the plan name, coverage period, and details on your deductible and out-of-pocket maximum.



Answers	Why This Matters:
Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

…ent and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

…l Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
…lth care …or	Primary care visit to treat an injury or illness	$35 copay/office visit and 20% coinsurance for other outpatient services. deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/visit	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
…t	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	
…s to …r …about …able at	Generic drugs (Tier 1)	$10 copay/prescription (retail & mail order)	40% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail & mail order)	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	40% coinsurance	60% coinsurance	
	Specialty drugs (Tier 4)	50% coinsurance	70% coinsurance	
…atient surgery	Facility fee (e.g., ambulatory surgery center)	$100/day copay	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance for anesthesia.

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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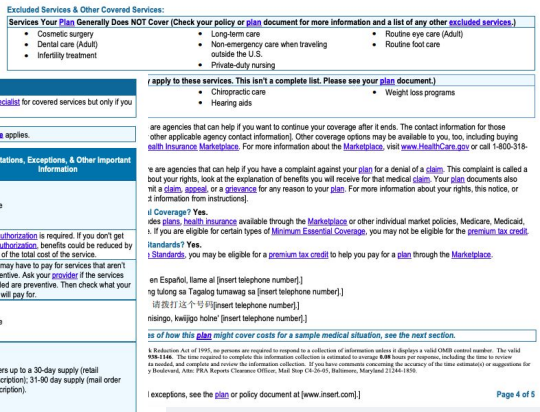
The next few pages of your SBC provides a list of common medical events, covered services, copays/coinsurance for in-network and out-of-network providers, and any exceptions for services.



Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

…apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids
- Weight loss programs

…are agencies that can help if you want to continue your coverage after it ends. The contact information for those …other applicable agency contact information]. Other coverage options may be available to you, too, including buying …alth Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-…

…re agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a …bout your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also …tell a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or …t information from instructions].

…l Coverage? Yes.

…ides plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, …. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

…tandards? Yes.

…Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

…en Español, llame al [insert telephone number].]

…ng tulong sa Tagalog tumawag sa [insert telephone number].]

请拨打这个号码[insert telephone number].]

…nisingo, kwiijigo holne' [insert telephone number].]

…e of how this plan might cover costs for a sample medical situation, see the next section.

…k Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid …938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review …ns needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for …y Boulevard, Attn: PRA Reports Clearance Office, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

…exceptions, see the plan or policy document at [www.insert.com].]

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After the list of covered services, you will see a box that shows services that are excluded, as well as a box that shows "other covered services" which typically have limitations applied.

Examples Of What Nonstop Health Covers – And What It Doesn't

Nonstop Health can be used to pay for all services and prescriptions that are covered under your medical plan. In essence this means that if your medical carrier has agreed to pay for a medical service or prescription as part of your medical coverage, then you can use your Nonstop Visa card to pay for it. If your carrier does not cover a service or prescription, then you will be responsible for 100% of those costs. If you're not sure if a service or prescription is covered, check your SBC or contact your carrier before receiving care.

Because medical plans cover services and prescriptions differently, there's not an exhaustive list of where you can/can't use your Nonstop Visa card. But below are a few examples of services/providers/facilities that are never covered by Nonstop Health. This is only a sample - if you are not sure if a service or prescription is covered, please check with your carrier before receiving care!

Amazon.com or FSA/HSA store **BetterHelp**

Weight Loss Programs

FullScripts **FreeSpira** **Massage Envy**

Carex **HSAStore.com** **PeopleCare**

TalkSpace **Hero Health**

What if I have more questions?

Contact us! Nonstop's member support team is here to help. We can be reached at 877.626.6057 or clientsupport@nonstophealth.com. We are open Monday-Friday, 6am-5pm PST.