MAKINA HEALTH COOP BENEFIT INFORMATION

Schedule of Benefits

PA = Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)*
Calendar Year Deductible	$1000 single/$2500 family	$1000 single/$2500 family
Coinsurance (applies only to certain services)	20%	20%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)	$3000 single/$5000 family	$3000 single/$5000 family
Office Visits		
Primary Care Provider Visit[3]	Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit[3])	Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit[3]	Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam	Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services		
Diagnostic Laboratory Tests[3]	Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays[3] **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only) **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse		
Outpatient - Office[3] **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services[3] **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Transitional[3] **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient – Including Residential[3] **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services		
Emergency Room[2] (waived if admitted)[3]	Deductible/Coinsurance	Deductible/Coinsurance
ER Physician Services[3]	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care (1 per year per insured member) [3]	Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services		
Outpatient Surgical/Ambulatory Surgical Care Centers[3] **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services[3] **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Rehabilitation[3] (limited to 60 days/year) **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services		
Prenatal Care	Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services** **PA**	**Deductible/Coinsurance**	Deductible/Coinsurance
Preventive Services		
Preventive Services[4] – ACA Required	Covered in Full	Deductible/Coinsurance
Preventive Services – Not ACA Required	Deductible/Coinsurance	Deductible/Coinsurance
Vision Services		
Children's Vision Exam	Not Covered	Not Covered
Children's Eye Glasses	Not Covered	Not Covered

Other Services			
Transplants[5] **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services (up to 20 visits/yr)	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (including manipulation therapy and limited to 20 visits each)	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits/yr)	Deductible/Coinsurance	Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/yr)	Deductible/Coinsurance	Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/yr)	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year) **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services	Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[6]	Not Covered	Deductible/Coinsurance
Routine Dental Care	Not Covered	Not Covered
Accidental Dental Services	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment		
Specialty Drugs (Curative ONLY) **PA**	Deductible/Coinsurance	Not Covered
Oral Chemotherapy Drugs	Deductible then 100%	Deductible then 100%
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years) **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices **PA if over $1,000**	Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies	Deductible/Coinsurance	Deductible/Coinsurance

Hearing Aids and Cochlear Implants (Limited to one aid per ear every 36 months)	Deductible/Coinsurance	Deductible/Coinsurance

This Schedule of Benefits does not replace the legal contract or certificate which identifies all covered services, additional details, limitations and exclusions of the coverage. For a complete description of covered services, please see your Certificate of Coverage and any amendments to your Benefit Plan. If you have questions regarding Makina Health Cooperative, please call us at 1-866-291-9449.

PA indicates Prior Authorization is required for these services. Call 1-888-342-7427 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit.

*If we do not contract with out-of-network providers, we have a maximum allowed amount that we will pay toward out-of-network care. If the doctor's charge is higher than our maximum allowed amount, the doctor (or facility) could decide to bill you for the difference, called "balance billing."

1.Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics. We cover up to $300 per visit.

2.After Copay (only apply to facility charge). All other charges related to ER visit are subject to deductible/coinsurance.

3.After Mini Med covers indicated visits, Deductible and Coinsurance applies

4.The Affordable Care Act (ACA) provides for coverage of certain preventive services based on age, gender and other health factors at no cost to the member.

5.Examples of transplants for which benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea when medically necessary and not experimental.

**Delivery and Inpatient Services are subject to a $2,500 Deductible plus Coinsurance. Elective C-sections are subject to a $5,000 Deductible.
If joining Makina Health Cooperative while pregnant a $5000 Deductible applies with a limitation of $15,000 in benefit for the delivery and inpatient services.**