High Deductible Health Plan (HDHP) Schedule of Benefits

	PPO *(Network)*	Non-PPO *(Out-Of-Network)*	Comments
Calendar Year Deductible: Per Covered Person Per Family	 $2,000 $4,000	 $2,000 $4,000	Deductibles for PPO and Non-PPO accumulate to one another. Includes medical and prescription drugs.
If family coverage is elected - For covered expenses that are subject to the deductible, the entire family calendar year deductible must be satisfied by a single covered person or a combination thereof. The "per covered person" deductible will not be applicable.			
Benefit Percentage: Medical Plan Pays Covered Person Pays	 80% (unless otherwise stated) 20%	 60% (unless otherwise stated) 40%	
Calendar Year Out-of-Pocket Maximum: *(Including Deductible)* Per Covered Person Per Family	 $6,550 $13,100	 $30,000 $60,000	Out-of-pocket maximums for PPO and Non-PPO accumulate to one another. Includes medical and prescription drugs.
The per person out-of-pocket maximum shall apply when family coverage is elected. No single family member shall be required to satisfy more than individual out of pocket maximum.			
The charges for the following do not accrue to the Out-of-Pocket Maximum and are never reimbursed at 100% by the Plan: • Cost Containment Penalties • Expenses incurred for Non-Covered Services			

Benefits and Services	PPO (Network) Plan Pays *Allowed Amount (After Deductible)	Non-PPO *(Out-Of-Network)* Plan Pays **UCR *(After Deductible)*	Comments
HOSPITAL BENEFITS			
Inpatient Hospital Services	80%	60%	*Pre-notification required.* Benefit based on Semi-private room rate .
Outpatient Hospital	80%	60%	
Skilled Nursing Facility	80%	60%	*Pre-notification required.* Limited to I 00 days per calendar year.
Inpatient Rehabilitation Facility	80%	60%	
Emergency Room	80%	Considered at the Network Benefit Level	Non-emergency use of the emergency room is not covered.

High Deductible Health Plan (HDHP) Schedule of Benefits

Benefits and Services	PPO *(Network)* Plan Pays *Allowed Amount *(After Deductible)*	Non-PPO *(Out-Of-Network)* Plan Pays **UCR *(After Deductible)*	Comments
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS			
Inpatient Mental Health Treatment	80%	60%	*Pre-notification required.*
Office Mental Health Treatment	80%	60%	This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit.
Inpatient Substance Abuse Treatment	80%	60%	*Pre-notification required.*
Office Substance Abuse Treatment	80%	60%	This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit.
Partial Hospitalization	80%	60%	*Pre-notification required.* Includes Behavioral health services and intensive outpatient programs.
MISCELLANEOUS SERVICES AND SUPPLIES BENEFITS			
Home Health Care	80%	60%	*Pre-notification required.* Limited to 60 visits per calendar year.
Hospice Care	80%	60%	*Pre-notification required for inpatient services.*
Ambulance Service	80%	Considered at the Network Benefit Level	*Pre-notification required.*
Durable Medical Equipment	80%	60%	
Clinical Trials	80%	60%	Refer to *Clinical Trials* in the *Covered Medical Expense* section.
Hearing Exams	80%	60%	Limited to one exam every 24 months.
Hearing Aids	80%	60%	Limited to one set of aids every 36 months up to a maximum benefit of$1,400.
Infertility Treatment	Based on service type and where received	60%	*Pre-notification required for ART services.* Limited to overall $25,000 in benefits per lifetime.
Other Covered Expenses	80%	60%	

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Benefits and Services	PPO (Network) Plan Pays *Allowed Amount (After Deductible)	Non-PPO *(Out-Of-Network)* Plan Pays **UCR *(After Deductible)*	Comments
PROFESSIONAL SERVICES BENEFITS			
Virtual Consultations	Paid according to provider of service		This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit.
Physician's Office Visits *Includes family and general physician, internist and OBIGYN physician*	80%	60%	This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit.
Specialist's Office Visits	80%	60%	
Urgent Care	80%	60%	No coverage for non-urgent use.
Inpatient Hospital Visit or Consultation	80%	60%	
Allergy Treatment	80%	60%	
Second Surgical Opinion	80%	60%	
Surgical Services	80%	60%	Includes surgeon and facility. *Pre-notification required for all In-patient and Outpatient surgical procedures.* Pre-notification not required for office surgery.
Transplant Services	80%	60%	
Diagnostic X-ray & Laboratory Expenses	80%	60%	
Advanced Imaging	80%	60%	*Pre-notification required.* Includes MRI, MRA, CT/ PET Scan and nuclear imaging.
Maternity Delivery	80%	60%	*Pre-notification required for inpatient services.*
Prenatal / Postnatal care, Breastfeeding Support.	100% *(Deductible Waived)*	60%	*As established by the Department of Health and Human Services (HHS) and pursuant to section 2713 of the Affordable Care Act.*
Breast Pump, Accessories / Supplies	100% *(Deductible Waived)*	60%	*One electric pump every 12 months. One manual pump per pregnancy. One pump accessories/supplies purchase if not eligible to purchase a new pump.*
Lactation Consultations	100% *(Deductible Waived)*	100% *(Deductible Waived)*	

High Deductible Health Plan (HDHP) Schedule of Benefits

Benefits and Services	PPO (Network) Plan Pays *Allowed Amount (After Deductible)	Non-PPO *(Out-Of-Network)* Plan Pays **UCR *(After Deductible)*	Comments
REHABILITATION THERAPY BENEFITS			
Chiropractic Care	80%	60%	Limited to 100 visits per calendar year.
Acupuncture Treatment	$50 Co-pay, then 100%	60%	Limited to 10 visits per calendar year.
Temporomandibular Joint Disorders (TMJ)	80%	60%	
Chemotherapy	80%	60%	
Radiation Therapy	80%	60%	
Cardiac Rehabilitation	Based on service type and where received	60%	
Cognitive Rehabilitation	Based on service type and where received	60%	
Pulmonary Rehabilitation	Based on service type and where received	60%	
Respiratory Therapy	Based on service type and where received	60%	
Gene-Based, Cellular and other Innovative Therapies (GCIT)	Based on service type and where received	Not Covered	*Pre-notification required.*
Gene Therapy Prescription Drugs	$50 Copay, then 100%	Not Covered	
Infusion Therapy			
Physician Office	80%	60%	
Infusion Location	Based on service type and where received	60%	
In the Home	80%	60%	
Hospital Outpatient Department	100%	60%	
Non-Hospital Facility	100%	60%	
Speech Therapy	80%	60%	20 visits/calendar year.
Physical Therapy	80%	60%	20 visits/calendar year.
Occupational Therapy	80%	60%	20 visits/calendar year.

High Deductible Health Plan (HDHP) Schedule of Benefits

Benefits and Services	PPO (Network) Plan Pays *Allowed Amount (After Deductible)	Non-PPO *(Out-Of-Network)* Plan Pays **UCR *(After Deductible)*	Comments
PREVENTIVE CARE BENEFITS			
Preventive Services *As established by section 2713 of the Affordable Care Act (ACA)*	100% *(Deductible Waived)*	60%	Refer to the *Covered Medical Expense* section under *Preventive* for additional information .
Well Child Care	100% *(Deductible Waived)*	60%	Coverage includes preventive care visits for well adult care, well woman care, and well childcare to obtain the recommended preventive services that are age appropriate and developmentally appropriate as outlined under Section 2713 of the ACA.
Well Adult Care	100% *(Deductible Waived)*	60%	
Mammogram	100% *(Deductible Waived)*	60%	Includes 3D mammograms.
GYN &Pap	100% *(Deductible Waived)*	60%	
PSA Testing	100% *(Deductible Waived)*	60%	
Colonoscopy	100% *(Deductible Waived)*	60%	
Routine Eye Care Includes refraction	100% *(Deductible Waived)*	60%	Eye exams are limited to one exam every 12 months. Supplies, including eyeglasses or contacts, are not covered.

* Allowed amount - The Plan will consider the allowed amount designated by the network.

** UCR-The Plan will consider the Usual and Customary and Reasonable amount of the services based on the geographic location of the provider of service.

This schedule is not all inclusive. Refer to the Covered Medical Expenses and Medical Exclusions and Limitations sections for more information.

High Deductible Health Plan (HDHP) Schedule of Benefits

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS *(Available through a separate Pharmacy Benefit Manager)*			
	Retail *30-day supply* *(After Deductible)*	Mail-Order *Up to 90-day supply* *(After Deductible)*	Comments
Generic* *(tier-1)*	$20 Copay, then 100%	$40 Copay, then 100%	Note that out-of-network prescriptions are covered by the Plan at 60%.
Preferred Brand *(tier-2)*	$40 Copay, then 100%	$80 Copay, then 100%	
Non-Preferred *(tier-3)*	$70 Copay, then 100%	$140 Copay, then 100%	
Specialty Medications *(tier-4)*			
Generic	$100 Copay, then 100%	N/A	
Preferred	$100 Copay, then 100%	N/A	
Non-Preferred	$200 Copay, then 100%	N/A	

* The Plan will cover charges for any preventive care drugs as required by the ACA. The Plan may use reasonable medical management techniques to control costs and promote efficient delivery of care, such as covering a generic drug without cost sharing and imposing cost sharing for equivalent branded drugs.

Your Doctor may prescribe a name brand drug that has a lower cost generic drug equivalent. If either drug is acceptable to your Doctor, you are encouraged to choose the generic drug from your pharmacist. However, if you choose the name brand drug, you must pay the difference in cost between the generic and name brand plus the higher co-pay. If your Doctor specifies that the name brand drug must be dispensed as prescribed, you will only have to pay the higher co-pay.

Questions about prescription benefits should be referred to RxBenefits Member Services at (800) 334-8134 or via email at customercare@rxbenefits.com.