# Network Services Only Schedule of Benefits

| | NSO *(Network)* | Non-NSO *(Out-Of-Network)* | Comments |
|---|---|---|---|
| **Calendar Year Deductible:**<br>Per Covered Person<br>Per Family | <br>$2,000<br>$4,000 | No Coverage | The prescription drug portion of this Plan has a separate deductible to satisfy. |
| **Benefit Percentage:**<br>Medical Plan Pays<br>Covered Person Pays | <br>90%<br>(unless otherwise stated)<br>10% | No Coverage | |
| **Calendar Year Out-of-Pocket Maximum:**<br>*(Including Deductible)*<br>Per Covered Person<br>Per Family | <br><br>$7,350<br>$14,700 | No Coverage | Includes medical and prescription drugs. |
| The charges for the following do not accrue to the Out-of-Pocket Maximum and are never reimbursed at 100% by the Plan:<br>• Cost Containment Penalties<br>• Expenses incurred for Non-Covered Services | | | |

| Benefits and Services | NSO (Network) Plan Pays *Allowed Amount (After Deductible) | Non-NSO *(Out-Of-Network)* Plan Pays **UCR *(After Deductible)* | Comments |
|---|---|---|---|
| **HOSPITAL BENEFITS** | | | |
| Inpatient Hospital Services | 90% | Not Covered | *Pre-notification required.* Benefit based on Semi-private room rate. |
| Outpatient Hospital | 90% | Not Covered | |
| Skilled Nursing Facility | 90% | Not Covered | *Pre-notification required.* Limited to 100 days per calendar year. |
| Inpatient Rehabilitation Facility | 90% | Not Covered | |
| Emergency Room | 90% | Considered at the Network Benefit Level | Non-emergency use of the emergency room is not covered. |
| **MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS** | | | |
| Inpatient Mental Health Treatment | 90% | Not Covered | *Pre-notification required.* |
| Office Mental Health Treatment | $50 Copay, then 100% *(Deductible Waived)* | Not Covered | This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. |

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|---|---|---|---|
| **MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS** *(continued)* | | | |
| Inpatient Substance Abuse Treatment | 90% | Not Covered | *Pre-notification required.* |
| Office Substance Abuse Treatment | $50 Copay, then 100% *(Deductible Waived)* | Not Covered | This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. |
| Partial Hospitalization | 90% | Not Covered | *Pre-notification required.* Includes Behavioral Health services and intensive outpatient programs. |
| **MISCELLANEOUS SERVICES AND SUPPLIES BENEFITS** | | | |
| Home Health Care | 100% | Not Covered | *Pre-notification required.* Limited to 60 visits per calendar year. |
| Hospice Care<br>Inpatient<br>Outpatient | <br>90%<br>100% | <br>Not Covered<br>Not Covered | *Pre-notification required for inpatient services.* |
| Ambulance Service | 90% | Considered at the Network Benefit Level | |
| Durable Medical Equipment | 90% | Not Covered | |
| Clinical Trials | Based on service type and where received | Not Covered | Refer to *Clinical Trials* in the *Covered Medical Expense* section. |
| Hearing Exams | 90% | Not Covered | Limited to one exam every 24 months. |
| Hearing Aids | 90% | Not Covered | 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 | Not Covered | *Pre-notification required for ART services.* Limited to overall $25,000 in benefits per lifetime. |
| Other Covered Expenses | 90% | Not Covered | |

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| Benefits and Services | **NSO** (Network) Plan Pays *Allowed Amount (After Deductible) | Non-NSO *(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<br>*Includes family and general physician, internist and OB/GYN physician* | $25 Copay, then 100%<br>*(Deductible Waived)* | Not Covered | Office visit includes other services rendered in the office.<br>This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. |
| Specialist's Office Visits | $50 Copay, then 100%<br>*(Deductible Waived)* | Not Covered | |
| Urgent Care | 90%<br>*(Deductible Waived)* | Not Covered | No coverage for non-urgent use. |
| Inpatient Hospital Visit or Consultation | 90% | Not Covered | |
| Allergy Treatment | 90% | Not Covered | |
| Second Surgical Opinion | 90% | Not Covered | |
| Surgical Services | 90% | Not Covered | Includes surgeon and facility.<br>*Pre-notification required for all In-patient and Outpatient surgical procedures.*<br>Pre-notification not required for office surgery. |
| Transplant Services | 90% | Not Covered | |
| Diagnostic X-ray & Laboratory Ex12enses | 90% | Not Covered | |
| Advanced Imaging | 90% | Not Covered | *Pre-notification required.*<br>Includes MRI, MRA, CT/PET Scan and nuclear imaging. |
| Maternity Delivery | 90% | Not Covered | *Pre-notification required for inpatient services.* |
| Prenatal / Postnatal care, Breastfeeding Support. | 100%<br>*(Deductible Waived)* | Not Covered | *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%<br>*(Deductible Waived)* | Not Covered | *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%<br>*(Deductible Waived)* | 100%<br>*(Deductible Waived)* | |

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| Benefits and Services | **NSO** (Network) Plan Pays *Allowed Amount (After Deductible) | Non-NSO *(Out-Of-Network)* Plan Pays **UCR *(After Deductible)* | Comments |
|---|---|---|---|
| **REHABILITATION THERAPY BENEFITS** | | | |
| Chiropractic Care | $50 Copay, then 100% *(Deductible Waived)* | Not Covered | Limited to 100 visits per calendar year. |
| Acupuncture Treatment | $25 Copay, then 100% *(Deductible Waived)* | Not Covered | Limited to 10 visits per calendar year. |
| Temporomandibular Joint Disorders (TMJ) | 90% | Not Covered | |
| Chemotherapy | Based on service type and where received | Not Covered | |
| Radiation Therapy | Based on service type and where received | Not Covered | |
| Cardiac Rehabilitation | Based on service type and where received | Not Covered | |
| Cognitive Rehabilitation | Based on service type and where received | Not Covered | |
| Pulmonary Rehabilitation | Based on service type and where received | Not Covered | |
| Respiratory Therapy | Based on service type and where received | Not Covered | |
| 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% *(Deductible Waived)* | Not Covered | |
| Infusion Therapy | | | |
| *Physician Office* | 90% | Not Covered | |
| *Infusion Location* | Based on service type and where received | Not Covered | |
| *In the Home* | 90% | Not Covered | |
| *Hospital Outpatient Department* | 90% | Not Covered | |
| *Non-Hospital Facility* | 90% | Not Covered | |

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|---|---|---|---|
| **REHABILITATION THERAPY BENEFITS** *(continued)* | | | |
| Speech Therapy | $50 Copay, then 100% *(Deductible Waived)* | Not Covered | 20 visits/calendar year. |
| Physical Therapy | $50 Copay, then 100% *(Deductible Waived)* | Not Covered | 20 visits /calendar year. |
| Occupational Therapy | $50 Copay, then 100% *(Deductible Waived)* | Not Covered | 20 visits/calendar year. |
| **PREVENTIVE CARE BENEFITS** | | | |
| Preventive Services *As established by section 2713 of the Affordable Care Act (ACA)* | 100% *(Deductible Waived)* | Not Covered | Refer to the *Covered Medical Expense* section under *Preventive* for additional information. 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 Child Care | 100% *(Deductible Waived)* | Not Covered | |
| Well Adult Care | 100% *(Deductible Waived)* | Not Covered | |
| Mammogram | 100% *(Deductible Waived)* | Not Covered | Includes 3D mammograms. |
| GYN & Pap | 100% *(Deductible Waived)* | Not Covered | |
| PSA Testing | 100% *(Deductible Waived)* | Not Covered | |
| Colonoscopy | 100% *(Deductible Waived)* | Not Covered | |
| Routine Eye Care Includes refraction | 100% *(Deductible Waived)* | Not Covered | 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.**

## Network Services Only Schedule of Benefits

## SCHEDULE OF PRESCRIPTION DRUG BENEFITS

| **PRESCRIPTION DRUG BENEFITS** *(Available through a separate Pharmacy Benefit Manager)* | | | |
|---|---|---|---|
| **Calendar Year Deductible:**<br>Per Covered Person<br>Per Family | | $200<br>$400 | |
| | **Retail**<br>*30-day supply*<br>***(After Deductible)*** | **Mail-Order**<br>*Up to 90-day supply*<br>***(After Deductible)*** | **Comments** |
| Generic*<br>*(tier-1)* | $20 Copay,<br>then 100% | $40 Copay,<br>then 100% | |
| Preferred Brand<br>*(tier-2)* | $40 Copay,<br>then 100% | $80 Copay,<br>then 100% | |
| Non-Preferred<br>*(tier-3)* | $70 Copay,<br>then 100% | $140 Copay,<br>then 100% | |
| Specialty Medications<br>*(tier-4)* | | | |
| *Generic* | 70% | N/A | |
| *Preferred* | 70% | N/A | |
| *Non-Preferred* | 70% | 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.**