### Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>Single: $2,500</td>
<td>Family: $5,000</td>
</tr>
<tr>
<td>Family coverage requires the family deductible to be met before coinsurance applies. The single deductible <strong>does not</strong> apply to family coverage. (Deductibles are combined network and non-network)</td>
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</tr>
<tr>
<td><strong>Out-of-Pocket Limit (OOP) (Single/Family)</strong></td>
<td>Single: $4,000</td>
<td>Family: $8,000</td>
</tr>
<tr>
<td>Family coverage requires the family OOP to be met before 100% coverage applies. The single OOP <strong>does not</strong> apply to family coverage. Out-of-Pockets are combined network and non-network; includes the deductible</td>
<td>Individual embedded: $7,150</td>
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</tr>
</tbody>
</table>

### Physician Home and Office Services

Primary Care Physician (PCP)/Specialty Care Physician (SCP)

Including office surgeries and allergy serum:
- allergy injections (PCP and SCP) and allergy testing
- non-routine mammograms
- diabetic education (regardless of outpatient setting)
- MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds

**20%**  **40%**

### Preventive Care Services

Services include but are not limited to:
- Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, routine vision and hearing screenings. Vision screening limited to basic screening in PCP office.
- Physician home and office visits (PCP/SCP)
- Other outpatient services at hospital/alternative care facility
- Routine mammograms
- Screening colorectal cancer exam/laboratory testing

All preventive services are limited to one of each service per year per covered member; if the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit.

No deductible/coinsurance **40%** (not subject to deductible)

### Emergency and Urgent Care

- Emergency Room services at hospital (facility/other covered services) **20%**  **20%**
- Urgent Care Center services **20%**  **20%**

### Maternity Services

**20%**  **40%**

### Inpatient and Outpatient Professional Services

Include but are not limited to:
- Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams

**20%**  **40%**

### Inpatient Facility Services

**20%**  **40%**

### Outpatient Surgery Hospital/Alternative Care Facility

- Surgery and administration of general anesthesia **20%**  **40%**

### Other Outpatient Services (including but not limited to):

- Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services.
- Home care services (network/non-network combined) Unlimited visits (includes IV therapy) **(No RN/LPN unless billed through a home health care agency)**
- Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies)
- Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply)
- Physical medicine therapy day rehabilitation programs
- Hospice care **20%**  **20%**
- Ambulance services **20%**  **20%**
**Covered Benefits**

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<tr>
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<tr>
<td><strong>Outpatient Therapy Services</strong></td>
<td></td>
<td></td>
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<tr>
<td>(Combined network and non-network limits apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Home and Office Visits (PCP/SCP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other outpatient services at hospital/alternative care facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical therapy: 25 visits</td>
<td>20%</td>
<td>40%</td>
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<tr>
<td>• Occupational therapy: 25 visits</td>
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<td></td>
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<tr>
<td>• Manipulation therapy: 12 visits</td>
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<tr>
<td>• Speech therapy: 25 visits</td>
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</tbody>
</table>

**Behavioral Health Services:**

**Mental Health and Substance Abuse**¹

- Inpatient facility services
- Physician home and office visits (PCP/SCP)
- Other outpatient services at hospital/alternative care facility

Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.

**Human Organ and Tissue Transplants**²

- Acquisition and transplant procedures, harvest and storage

| Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS³ |
|-------------------------------------------------|-------------------|------------------|
| Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum | Retail Rx (Up to a 30-day supply) | Mail Order Rx (Up to a 90-day supply) |
| Generic                                        | $10 co-pay        | $20 co-pay       |
| Formulary                                      | 20% - minimum $30, maximum $50 | 20% - minimum $60, maximum $100 |
| Brand Non-Formulary                            | 40% - minimum $50, maximum $70 | 40% - minimum $100, maximum $140 |
| Specialty                                      | 40% - minimum $75, maximum $150 (30-day supply only) |         |
| Preventive Rx (mandated by the ACA)            | $0                | (no deductible)  |

**Notes:**

- Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.
- Dependent Age: to end of the month in which the child attains age 26
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit Period = calendar year.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Skilled Nursing Facility – limited to 100 days.

¹We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

²Kidney and cornea are treated the same as any other illness and subject to the medical benefits.

³PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO (877)841-5241

**Precertification:**

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

*This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.*