# General Information

## Cost Sharing Expenses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Deductible - Single | $0 | Not Covered | |
| Deductible - Family | $0 | Not Covered | |
| Deductible Aggregation - Single and Family | | | Each family member is only subject to the single Deductible and any combination of family members can satisfy the family Deductible as long as one individual does not meet more than the single deductible.<br>Individual |
| Coinsurance | 0% | Not Covered | |
| Annual Out of Pocket Maximum - Single | $6,350 | Not Covered | Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services. |
| Annual Out of Pocket Maximum - Family | $12,700 | Not Covered | Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services. |
| Annual Out of Pocket Maximum Aggregation - Single and Family | | | Each family member is only subject to the single Annual Out of Pocket Maximum any combination of family members can satisfy the family Annual Out of Pocket Maximum.<br>Individual |

## Office Visit Cost Shares

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Cost Share - Primary Care | $15 Copayment | Not Covered | |
| Cost Share - Specialist | $15 Copayment | Not Covered | |

## Plan Limits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Plan/Calendar Year | | | Calendar Year Benefits |
| Diabetic Preauthorization and Step Therapy | | | No |

## Who is Covered

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Domestic Partner Coverage | | | Not Covered |

# Inpatient Services

### Inpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Services | Covered in Full | Not Covered | |
| Mental Health Care | Covered in Full | Not Covered | |
| Substance Use Detoxification | Covered in Full | Not Covered | |
| Skilled Nursing Facility | Covered in Full | Not Covered | 120 Days per year |
| Physical Rehabilitation | Covered in Full | Not Covered | 60 Days per year |
| Maternity Care | Covered in Full | Not Covered | |

### Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Surgery | PCP/Specialist - Covered in Full | Not Covered | |
| Anesthesia | PCP/Specialist - Covered in Full | Not Covered | Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral. |

## Outpatient Facility Services

### Outpatient Facility Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| SurgiCenters and Freestanding Ambulatory Centers Surgical Care | $15 Copayment | Not Covered | |
| Diagnostic X-ray | $15 Copayment | Not Covered | |
| Diagnostic Laboratory and Pathology | Covered in Full | Not Covered | |
| Radiation Therapy | Covered in Full | Not Covered | |
| Chemotherapy | Covered in Full | Not Covered | |
| Chemotherapy Medications | | | |
| Infusion Therapy Outpatient | Inclusive of Primary Services | Not Covered | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis | Covered in Full | Not Covered | |
| Mental Health Care | $15 Copayment | Not Covered | Includes Partial Hospitalization |
| Substance Use Care | $15 Copayment | Not Covered | Includes Partial Hospitalization |

## Home and Hospice Care

### Home Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Home Care | Covered in Full | Not Covered | |
| Home Infusion Therapy | Covered in Full | Not Covered | |

### Hospice Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Hospice Care Inpatient | Covered in Full | Not Covered | |

## Outpatient and Office Professional Services

### Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Office Surgery | PCP/Specialist - $15 Copayment | Not Covered | |
| Diagnostic X-ray | PCP/Specialist - $15 Copayment | Not Covered | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - Covered in Full | Not Covered | |
| Radiation Therapy | PCP/Specialist - Covered in Full | Not Covered | |
| Chemotherapy | PCP/Specialist - Covered in Full | Not Covered | |
| Infusion Therapy Services | PCP/Specialist - Inclusive of Primary Services | Not Covered | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis | PCP/Specialist - Covered in Full | Not Covered | |
| Mental Health Care | PCP/Specialist - $15 Copayment | Not Covered | |
| Maternity Care | PCP/Specialist - Covered in Full | Not Covered | |
| Telehealth | PCP/Specialist - $15 Copayment | Not Covered | |
| TeleMedicine Program | PCP/Specialist - $5 Copayment<br>$0 PCP Copay for members to age 19. | Not Covered | Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions. |
| Chiropractic Care | PCP/Specialist - $15 Copayment | Not Covered | |
| Allergy Testing | PCP/Specialist - $15 Copayment<br>$0 PCP Copay for members to age 19. | Not Covered | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - $15 Copayment<br>$0 PCP Copay for members to age 19. | Not Covered | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - Not Covered | Not Covered | Not Covered |

## Rehab and Habilitation

### Outpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Physical Rehabilitation | $15 Copayment | Not Covered | 45 Visits per year<br>Includes aggregate of visits for professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | $15 Copayment | Not Covered | 45 Visits per year |
| Speech Rehabilitation | $15 Copayment | Not Covered | 45 Visits per year |

### Outpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Physical Rehabilitation | PCP/Specialist - $15 Copayment | Not Covered | 45 Visits per year<br>Includes aggregate of visits for professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | PCP/Specialist - $15 Copayment | Not Covered | 45 Visits per year |
| Speech Rehabilitation | PCP/Specialist - $15 Copayment | Not Covered | 45 Visits per year |

## Preventive Services

### Preventive Professional Services Meeting Federal Guidelines*

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Adult Physical Examination | PCP/Specialist - Covered in Full | Not Covered | 1 Exam per year |
| Adult Immunizations | PCP/Specialist - Covered in Full | Not Covered | |
| Well Child Visits and Immunizations | PCP/Specialist - Covered in Full | Not Covered | |
| Routine GYN Visit | PCP/Specialist - Covered in Full | Not Covered | 1 Exam per year |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | Not Covered | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | Not Covered | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | Not Covered | |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | Not Covered | |

### Preventive Facility Services Meeting Federal Guidelines*

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Cervical Cytology Preventative | Covered in Full | Not Covered | 1 Exam per year |
| Mammography Screening Facility | Covered in Full | Not Covered | |
| Colonoscopy Screening Facility | Covered in Full | Not Covered | |
| Bone Density Screening Facility | Covered in Full | Not Covered | |

### Preventive services in addition to those required under Federal Guidelines - Professional

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Prostate Cancer Screening | PCP/Specialist - $15 Copayment | Not Covered | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | Not Covered | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | Not Covered | |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | Not Covered | |

### Preventive services in addition to those required under Federal Guidelines - Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Mammography Screening Facility | Covered in Full | Not Covered | |
| Colonoscopy Screening Facility | Covered in Full | Not Covered | |
| Bone Density Screening Facility | Covered in Full | Not Covered | |

# Other Benefits

## Additional Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Treatment of Diabetes Preventive | N/A | N/A | |
| Treatment of Diabetes - Non-Insulin Drugs and Supplies | PCP/Specialist - $15 Copayment | Not Covered | Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. |
| Treatment of Diabetes - Insulin | PCP/Specialist - $15 Copayment | Not Covered | Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. |
| Diabetic Equipment | PCP/Specialist - $15 Copayment | Not Covered | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance | Not Covered | |
| Medical Supplies | PCP/Specialist - 20% Coinsurance | Not Covered | |
| Acupuncture | PCP/Specialist - 50% Coinsurance | 50% Coinsurance Subject to Deductible | 10 Visits Per Contract Year |
| Private Duty Nursing | PCP/Specialist - Not Covered | Not Covered | Not Covered |

## Diagnoses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Reimbursement for Travel and Lodging Expenses | PCP/Specialist - Not Covered | Not Covered | Not Covered |

# Emergency Services

## ER Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Facility Emergency Room Visit | $50 Copayment | $50 Copayment | Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. |

## Transportation

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Prehospital Emergency and Transportation - Ground or Water | $15 Copayment | $15 Copayment | |

## Urgent Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Urgent Care Center Facility Visit | $25 Copayment | Not Covered | |

# Total Health Management Programs

### Wellness Programs

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Wellbeing Program | | | Members can earn up to $300 per plan year in rewards that can be used to purchase gift cards, fitness tracking devices or various other health and wellness items. Rewards are earned by completing gamification-style activities, including health challenges and journeys, daily cards, healthy habit tracking, and $50 can be earned for completing a Health Risk Assessment that motivates them to focus on their total health and wellbeing.<br>ThriveWell Rewards |
| Reward Amount | | | Rewards 5 $300 EE only w/ $50 HRA & $150 Preventive Screening |

## Ancillary Benefits

### Vision

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Pediatric Eye Exams - Routine | $15 Copayment | Not Covered | 1 Exam per year |
| Pediatric Eyewear - Routine | 20% Coinsurance | Not Covered | 1 Pair per year |
| Adult Eye Exams - Routine | $15 Copayment | Not Covered | 1 Exam per year |
| Adult Eyewear - Routine | Covered | Not Covered | $100 Reimbursement per year |

## Rx Benefits

### Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Rx Plan | | | $5/$20/$35 |

### Rx Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Days Supply Per Retail Order | 90 | | |
| Days Supply Per Mail Order | 90 | | |
| Copays Per Mail Order Supply | 1 | | |

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.