

Cost Summary**Annual Deductible**

	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	\$3,500	\$7,000
Family	\$7,000	\$14,000

Out-of-Pocket Maximum

	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	\$8,500	\$17,000
Family	\$17,000	\$34,000

Coinsurance (After Deductible)

Member Pays	30%	50%
Employer HSA Contribution	Contribution Determined by Employer	
Plan HSA Contribution	0	

Schedule of Benefits

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Professional Services			
Physician Office Services <i>Primary Care Physician</i>	No	Deductible & Coinsurance	Deductible & Coinsurance
Physician Office Services <i>Specialist Office Visit (includes mental & behavioral health)</i>	No	Deductible & Coinsurance	Deductible & Coinsurance
Physician Office Services <i>Urgent Care</i>	No	Deductible & Coinsurance	Deductible & Coinsurance
Other Physician Services Performed in the Office	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Chiropractic Care	No	Deductible & Coinsurance (30 visits/plan year)	Deductible & Coinsurance
Therapy — Physical, Speech, Occupational, ABA & Cardiac	Yes, after 12 visits	Deductible & Coinsurance (24 visits/plan year combined)	Deductible & Coinsurance
Telemedicine (through MYMDNOW)	No	\$0 Copay	Not Covered
Diagnostic Services			
Labs	No	Deductible & Coinsurance	Deductible & Coinsurance
X-rays	No	Deductible & Coinsurance	Deductible & Coinsurance
Advanced Imaging <i>CT / MRI / MRA / Ultrasound / PET Scan</i>	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Services <i>For a true emergency, any provider may be used without penalty or denial</i>			
Emergency Room Facility & Covered Services	No	Deductible & Coinsurance	Deductible & Coinsurance
Ambulance	No	Deductible & Coinsurance (Ground transportation coverage Only)	Deductible & Coinsurance
Inpatient or Partial Hospitalization Services			
Inpatient Hospital Care Facility	Yes	Deductible & Coinsurance (PHP/IOP 30-day limit/plan year)	Deductible & Coinsurance
Associated / Incidental Inpatient Services	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital Surgical Services	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Rehabilitation / Skilled Nursing Facility	Yes	Deductible & Coinsurance (14-day limit/plan year combined)	Deductible & Coinsurance

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Hospice	Yes	Deductible & Coinsurance (60-day limit/lifetime)	Deductible & Coinsurance
Organ Transplant	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Services			
Outpatient Surgical Facility <i>Outpatient hospital or ambulatory surgery center</i>	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery Services <i>Surgeon, anesthesia, and any associated services</i>	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Chemotherapy & Radiotherapy <i>Chemotherapy includes infusion only, not oral</i>	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Dialysis	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Preventive Care Services			
Preventive Care <i>Annual wellness exams, labs, and immunizations (see Preventive Care Guide)</i>	No	\$0 Copay /\$0 Deductible	Not Covered
Maternity Services			
Maternity / Childbirth / Delivery	Yes if exceeds 48/96 rule	Deductible & Coinsurance	Deductible & Coinsurance
Maternity Professional Services <i>Office visits, lab work, radiology, prenatal and postnatal care</i>	No	Deductible & Coinsurance	Deductible & Coinsurance
Other Covered Services			
Home Health Care Visits	Yes	Deductible & Coinsurance (30 visits/plan year)	Deductible & Coinsurance
Durable Medical Equipment (DME) <i>Subject to limitations</i>	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Nutritional Counseling	No	Deductible & Coinsurance (1 visit/plan year)	Not Covered
Prosthetics	Yes	Deductible & Coinsurance (1 item/plan year)	Deductible & Coinsurance
Allergy Testing / Injections	No	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Care — Substance Abuse Detoxification Facility	Yes	Deductible & Coinsurance (5-day limit/plan year)	Deductible & Coinsurance
Inpatient / Outpatient Treatment for Chemical Abuse & Dependency	Yes	Deductible & Coinsurance (30-day limit/plan year, includes PHP/IOP)	Deductible & Coinsurance
Pharmacy Benefits			
Drug Tier		Prior Auth	Member Pays (Participating Pharmacy)
All prescriptions must appear on the plan formulary			
Generic — Maintenance / Preventive Rx only <i>Total drug cost must be under \$200; otherwise, subject to the deductible and applicable copay</i>		No	\$0 Copay*
Generic		No	Deductible & Coinsurance**
Preferred Brand Drugs		No	Deductible & Coinsurance**
Non-Preferred Drugs / Specialty		Yes	Deductible & Coinsurance**

Important Notes

1. Failure to obtain required authorization may result in penalties, including a 50% reduction of allowed charges or denial of the claim.
2. In a true emergency (such as a severe injury or life-threatening condition), you may go to the nearest emergency room with no out-of-network penalty or claim denial.
3. If authorization is required following an emergency admission, it must be obtained within 48 hours or by the next business day.
4. *GENERIC MEDICATIONS THAT ARE COVERED AT \$0 ONLY PERTAIN TO THESE CONDITIONS:
 1. Diabetes Medications (Glucose-Lowering Agents, Insulin)
 2. High Blood Pressure / Cardiovascular (ACE Inhibitors, Beta-Blockers, Antihypertensives)
 3. Cholesterol-Lowering (Statins and Others)
 4. Asthma / Respiratory (Inhaled Corticosteroids and Related)
 5. Osteoporosis (Anti-resorptive Therapy)
 6. Mental Health (for Depression)
 7. Anticoagulants / Antiplatelets
 8. Contraceptives (Expanded in 2024 Guidance)All other medications subject to deductible.
5. **ONLY MEDICATIONS UNDER \$200 WILL BE COVERED BY THIS PLAN