## SUMMARY OF BENEFITS EPO 250

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| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **MEDICAL DEDUCTIBLE, PER PLAN YEAR** | | |
| Per Covered Person | $250 | |
| Per Family Unit | $750 | |
| Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met. | | |
| **MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR** | | |
| Per Covered Person | $3,400 | |
| Two Party | $6,800 | |
| Per Family Unit | $10,000 | |
| The Plan will pay the designated percentage of Maximum Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise. | | |
| The following charges do not apply toward the medical plan out-of-pocket maximum and are never paid at 100%, unless required by law:<br>• Cost containment penalties<br>• Amounts over the Maximum Allowable Amount<br>• Outpatient Prescription Drug charges | | |
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Percentage Payable –** unless otherwise stated. | 100% after deductible for Covered Services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts. | Covered Services from non-contracted (out of network) providers are not covered except in cases of emergency, authorized out of network referral or as required by law. Members are always responsible for covered charges in excess of Maximum Allowable Amounts, except as described in the Surprise Medical Bills Notice. |
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Abortion** – Elective | 100% after deductible | Not covered |
| **Acupuncture Services** | 100% after deductible;<br>12 visits Plan Year maximum | Not covered |
| **Advanced Imaging (Including CAT Scans, MRI, PET Scans) -** Pre-authorization is required. | 100% after $50 copayment per date of service and deductible | Not covered |
| **Ambulance Service -** Pre-authorization is required for non-emergent transport. | 100% after deductible | 100% after deductible |
| **Bariatric Surgical Procedures –** Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required. | | |
| Bariatric Surgical Procedures – Facility | 100% after deductible | Not covered |
| Bariatric Surgical Procedures – Physician | 100% after deductible | Not covered |
| Bariatric Surgical Procedures – Travel Charges– Coverage is available when the closest BDCSC and CME is 50 miles or more from the Covered Person's residence. | 100%; deductible waived;<br>$3,000 maximum per surgery | |
| **Blood** | 100% after deductible | Not covered |
| **Diabetes Education** | 100% after $25 copayment; deductible waived | Not covered |

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|---|---|---|
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Diabetes Supplies** (such as insulin pumps and glucometers) | 100% after deductible | Not covered |
| **Dialysis** | 100% after deductible | Not covered |
| **Durable Medical Equipment -** Pre-authorization is required. | 100% after deductible | Not covered |
| **Emergency Room Visit –** Including professional services | 100% after $150 copayment and deductible; Copayment waived if admitted. | 100% after $150 copayment and deductible; Copayment waived if admitted. |
| **Foot Orthotics** – Pre-authorization Required | 100% after deductible | Not covered |
| **Hearing Aids** | 100% after deductible<br>$2,500 maximum per ear every 36 months<br>This maximum will not apply to medically necessary hearing aids for children up to age 18. | 100% after deductible<br>$2,500 maximum per ear every 36 months<br>This maximum will not apply to medically necessary hearing aids for children up to age 18. |
| **Home Health Care -** Pre- authorization is required. | 100% after deductible;<br>100 visits Plan Year maximum; one visit by a home health aide equals four hours or less | Not covered |
| **Hospice Care** | 100%; deductible waived | Not covered |
| Bereavement Counseling | 100%; deductible waived | Not covered |
| **Hospital Services** | | |
| Inpatient - the semiprivate room rate. Pre-authorization is required. | 100% after deductible | Not covered |
| Ambulatory/Outpatient Surgery Facilities.* Pre-authorization is required for certain procedures. | 100% after deductible | Not covered |
| Outpatient Services - Pre-authorization is required for certain services. | 100% after deductible | Not covered |
| **Infusion Therapy** (Pre-authorization required) | 100% after deductible | Not covered |
| **Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)** | 100% after deductible | Not covered |
| **Lab & X-ray –** includes pre-admission testing. | 100% after $10 copayment per date of service and deductible | Not covered |
| **LiveHealth Online telemedicine: Medical & Behavioral Health** | 100% after $10 copayment, deductible waived | N/A |
| **Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health** | Covered the same as any other care based on type of service rendered | Not Covered |
| **Mental Disorders** | | |
| Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies. | 100% after deductible | Not covered |
| Outpatient - Pre-authorization is required for certain services. | 100% after deductible | Not covered |
| Office Setting | 100% after $25 copayment; deductible waived | Not covered |
| **Nutritional Evaluation and Counseling –** coverage for eating disorders only | 100% after deductible | Not covered |

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| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Organ Transplants –** for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required. | Covered the same as any other care based on type of service rendered | Not covered |
| Bone Marrow / Stem Cell Unrelated Donor Searches | 100% after deductible;<br>$30,000 maximum per transplant | Not covered |
| Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence. | 100%; deductible waived;<br>$10,000 maximum per transplant | |
| **Physician Services** | | |
| Inpatient visits | 100% after deductible | Not covered |
| Office visits | 100% after $25 copayment; deductible waived | Not covered |
| Specialist Office visit | 100% after $35 copayment; deductible waived | Not covered |
| Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies | 100% after deductible | Not covered |
| Second Surgical Opinion | 100% after $25 copayment or $35 specialist copayment;<br>deductible waived | Not covered |
| Surgery (Inpatient and Outpatient) | 100% after deductible | Not covered |
| Assistant Surgeon and Anesthesiologists | 100% after deductible | Not covered |
| Allergy injections, serum and testing | 100% after deductible | Not covered |
| Contraceptive Methods | 100%; deductible waived | Not covered |
| **Pregnancy** | | |
| Prenatal visits | 100%; deductible waived | Not covered |
| Postnatal visits | 100% after $25 copayment; deductible waived | Not covered |
| Delivery and All Other Services | Covered the same as any other care based on type of service rendered | Not covered |
| **Preventive Care** – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers. | | |
| Routine Well Care – All ages | 100%; deductible waived | Not covered |
| Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications) | 100%; deductible waived | Not covered |
| **Prosthetics**<br>Pre-authorization is required for certain prosthetics | 100% after deductible | Not covered |
| **Rehabilitation –** includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary | 100% after deductible;<br>24 visits Plan Year maximum combined with spinal manipulation / chiropractic | Not covered |

*If Emergency Services are provided at an Ambulatory Surgical Center, the Plan's terms and conditions for coverage (including cost sharing and whether prior authorization applies) may be different than what is shown above, to conform with the requirements of the No Surprises Act.

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| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Sex Change / Transgender Surgical Procedures -** Pre- authorization is required. | 100% after deductible | Not covered |
| Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence. | 100%; deductible waived; $10,000 maximum per surgery or series of surgeries | |
| **Skilled Nursing Facility –** the facility's semiprivate room rate. Pre-authorization is required. | 100% after deductible; 100 days Plan Year maximum | Not covered |
| **Speech Therapy** | 100% after deductible | Not covered |
| **Spinal Manipulation / Chiropractic** | 100% after deductible; 24 visits Plan Year maximum combined with Rehabilitation | Not covered |
| **Substance Abuse** | | |
| Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies. | 100% after deductible | Not covered |
| Outpatient - Pre-authorization is required for certain services. | 100% after deductible | Not covered |
| Office Setting | 100% after $25 copayment; deductible waived | Not covered |
| **Urgent Care –** includes physician services | 100% after $25 copayment; deductible waived | 100% after $25 copayment; deductible waived |
| **Voluntary Sterilization** | | |
| Female | 100%; deductible waived | Not covered |
| Male | 100% after deductible | Not covered |
| **Wigs** | Not covered | Not covered |

**PRESCRIPTION DRUG BENEFIT SUMMARY EPO 250**

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number. Please contact the Prescription Drug Administrator for additional information.

**Dispense As Written (DAW) Penalty.** If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

| SUMMARY OF BENEFITS EPO 250 | | |
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| **COVERED CHARGES** | **NETWORK PROVIDERS** | **NON-NETWORK PROVIDERS** |
| **PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.** | | |
| Per Covered Person | $1,600 | Unlimited |
| Per Family Unit | $3,200 | Unlimited |
| Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise. | | |
| The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%:<br>• Charges for Medical Services<br>• Charges in excess of the prescription drug plan Maximum Allowable Amount | | |
| **Retail Pharmacy Option (30 Day Supply)** | | |
| Tier 1 – Typically Generic Drugs | 100% after $10 copayment | 100% of Maximum Allowable Amount after $10 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount |
| Tier 2 - Preferred Brand Name Drugs | 100% after $25 copayment | 100% of Maximum Allowable Amount after $25 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount |
| Tier 3 - Non-Preferred Brand Name Drugs | 100% after $50 copayment | 100% of Maximum Allowable Amount after $50 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount |
| **Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)** | | |
| Tier 1 – Typically Generic Drugs | 100% after $15 copayment | 100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount |
| Tier 2 - Preferred Brand Name Drugs | 100% after $38 copayment | 100% of Maximum Allowable Amount after $38 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount |
| Tier 3 - Non-Preferred Brand Name Drugs | 100% after $75 copayment | 100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount |

| Mail Order Option (90 Day Supply) | | |
|---|---|---|
| Tier 1 – Typically Generic Drugs | 100% after $15 copayment | Not covered |
| Tier 2 - Preferred Brand Name Drugs | 100% after $38 copayment | Not covered |
| Tier 3 - Non-Preferred Brand Name Drugs | 100% after $75 copayment | Not covered |
| Tier 4 - Specialty Pharmacy – must be obtained through Specialty Mail Order Service. 30-day supply only. | Generic Specialty: 100% after $150 copayment<br><br>Non-Generic Specialty: 20% coinsurance<br><br>(member cost share can be reduced by availability of and participation in copay assistance programs) | Not covered |

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

**Refer to the Prescription Drug Section for details on the Prescription Drug benefit.**