**SUMMARY OF BENEFITS HDHP 1600**

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives you greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

| SUMMARY OF BENEFITS HDHP 1600 | | |
|---|---|---|
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **DEDUCTIBLE, PER PLAN YEAR - Network and Non-Network Deductibles are combined.** | | |
| Single | $1,600 | |
| Family Unit | $3,200 | |
| For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge.<br><br>For family coverage, the Aggregate Deductible must be met as a Family Unit before any money is paid by the Plan for any Covered Charge. | | |
| **MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of- Pocket amounts are combined.** | | |
| Single | $5,000 | |
| Family Unit | $10,000 | |
| For single coverage, the Plan will pay the designated percentage of 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.<br><br>The Family out-of-pocket includes an embedded out-of-pocket whereby once an individual reaches single covered out-of-pocket costs, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Plan Year unless stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Plan Year unless stated otherwise. | | |
| The following charges do not apply toward the 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 | | |
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.** | | |
| **Percentage Payable –** unless otherwise stated. | 90% after deductible for Covered Services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts. | 70% after deductible for Covered Services from non-contracted (out of network) providers. 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 | 90% after deductible | 70% after deductible |
| **Acupuncture Services** | 90% after deductible;<br>12 visits Plan Year maximum | 70% after deductible;<br>12 visits Plan Year maximum |
| **Advanced Imaging (Including CAT Scans, MRI, PET Scans) -** Pre-authorization is required. | 90% after deductible | 70% after deductible;<br>$800 maximum per procedure |

| SUMMARY OF BENEFITS HDHP 1600 | | |
|---|---|---|
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Ambulance Service -** Pre-authorization is required for non-emergent transport. | 90% after deductible | 90% after deductible;<br>. |
| **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 | 90% after deductible | Not covered |
| Bariatric Surgical Procedures - Physician | 90% after deductible | Not covered |
| Bariatric Surgical Procedures – Travel Charges– Coverage is available when the closest CME is 50 miles or more from the Covered Person's residence. | 100% after deductible;<br>$3,000 maximum per surgery | |
| **Blood** | 90% after deductible | 70% after deductible |
| **Diabetes Education** | 90% after deductible | 70% after deductible |
| **Diabetes Supplies** (such as insulin pumps and glucometers) | 90% after deductible | 70% after deductible |
| **Dialysis** | 90% after deductible | 70% after deductible;<br>$350 maximum per visit for all services and supplies |
| **Durable Medical Equipment -** Pre-authorization is required. | 90% after deductible | 70% after deductible |
| **Emergency Room Visit –** Including professional services | 90% after deductible | 90% after deductible |
| **Foot Orthotics -** Pre-authorization is required. | 90% after deductible | 70% after deductible |
| **Hearing Aids** | 90% 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. | 90% 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. | 90% after deductible;<br>100 visits Plan Year maximum; one visit by a home health aide equals four hours or less | 70% after deductible;<br>100 visits Plan Year maximum; one visit by a home health aide equals four hours or less |
| **Hospice Care** | 90% after deductible | 70% after deductible |
| Bereavement Counseling | 90% after deductible | 70% after deductible |
| **Hospital Services** | | |
| Inpatient - the semiprivate room rate. Pre-authorization is required. | 90% after deductible | 70% after deductible |
| Ambulatory/Outpatient Surgery Facilities.* Pre-authorization is required for certain procedures. | 90% after deductible | 70% after deductible;<br>Ambulatory Surgical Centers are limited to $350 per admit for all services |
| Outpatient Services - Pre-authorization is required for certain services. | 90% after deductible | 70% after deductible |
| **Infusion Therapy**<br>(Pre-authorization require) | 90% after deductible | 70% after deductible;<br>$600 per day maximum for all home infusion services and supplies |

| SUMMARY OF BENEFITS HDHP 1600 | | |
|---|---|---|
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)** | 90% after deductible | 70% after deductible |
| **Lab & X-ray –** includes pre-admission testing. | 90% after deductible | 70% after deductible |
| **LiveHealth Online telemedicine: Medical & Behavioral Health** | 90% after deductible** | N/A |
| **Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health** | Covered the same as any other care based on type of service rendered | Covered the same as any other care based on type of service rendered |
| **Mental Disorders** | | |
| Inpatient - the facility's semiprivate room rate. Pre-authorization is required. | 90% after deductible | 70% after deductible |
| Outpatient - Pre-authorization is required for certain services. | 90% after deductible | 70% after deductible |
| Office Setting | 90% after deductible | 70% after deductible |
| **Nutritional Evaluation and Counseling –** coverage for eating disorders only | 90% after deductible | 70% after deductible |
| **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 | 90% after deductible;<br>$30,000 maximum per transplant | 70% after deductible;<br>$30,000 maximum per transplant |
| 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% after deductible;<br>$10,000 maximum per transplant | |
| **Physician Services** | | |
| Inpatient visits | 90% after deductible | 70% after deductible |
| Office visits | 90% after deductible | 70% after deductible |
| Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies | 90% after deductible | 70% after deductible |
| Second Surgical Opinion | 90% after deductible | 70% after deductible |
| Surgery (Inpatient and Outpatient) | 90% after deductible | 70% after deductible |
| Assistant Surgeon and Anesthesiologists | 90% after deductible | 70% after deductible |
| Allergy injections, serum and testing | 90% after deductible | 70% after deductible |
| Contraceptive Methods | 100%; deductible waived | 70% after deductible |
| **Pregnancy** | | |
| Prenatal visits | 100%; deductible waived | 70% after deductible |
| Postnatal visits | 90% after deductible | 70% after deductible |
| Delivery and All Other Services | Covered the same as any other care based on type of service rendered | Covered the same as any other care based on type of service rendered |

*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.

**To the extent permitted by federal guidance, telemedicine visits may be covered without any cost sharing without impacting an individual's eligibility to contribute to a Health Savings Account.

| SUMMARY OF BENEFITS HDHP 1600 | | |
|---|---|---|
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Prescription Drug Benefit**<br>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.<br><br>**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. | | |
| Retail Pharmacy Option (30 Day Supply) | | |
| Tier 1 – Typically Generic Drugs | 100% after deductible and $10 copayment | 100% after deductible and $10 copayment; plus all charges in excess of the Maximum Allowable Amount |
| Tier 2 - Preferred Brand Name Drugs | 100% after deductible and $25 copayment | 100% after deductible and $25 copayment; plus all charges in excess of the Maximum Allowable Amount |
| Tier 3 - Non-Preferred Brand Name Drugs | 100% after deductible and $50 copayment | 100% after deductible and $50 copayment; plus 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 deductible and $20 copayment | 100% after deductible and $20 copayment; plus all charges in excess of the Maximum Allowable Amount |
| Tier 2 - Preferred Brand Name Drugs | 100% after deductible and $50 copayment | 100% after deductible and $50 copayment; plus all charges in excess of the Maximum Allowable Amount |
| Tier 3 - Non-Preferred Brand Name Drugs | 100% after deductible and $100 copayment | 100% after deductible and $100 copayment; plus all charges in excess of the Maximum Allowable Amount |
| **Mail Order Option (90 Day Supply)** | | |
| Tier 1 – Typically Generic Drugs | 100% after deductible and $20 copayment | Not covered |
| Tier 2 - Preferred Brand Name Drugs | 100% after deductible and $50 copayment | Not covered |
| Tier 3 - Non-Preferred Brand Name Drugs | 100% after deductible and $100 copayment | Not covered |
| Tier 4 - Specialty Pharmacy – must be obtained through Specialty Mail Order Service. 30- day supply only. | Generic Specialty: 100% after deductible and $150 Copayment. Non-Generic Specialty: 20% coinsurance after deductible. (member cost share can be reduced by availability of and participation in Plan copay assistance programs) | 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 | 70% after deductible |
| Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications) | 100%; deductible waived | Not covered |

| SUMMARY OF BENEFITS HDHP 1600 | | |
|---|---|---|
| **COVERED CHARGES** | **WHAT THE PLAN PAYS NETWORK PROVIDERS** | **WHAT THE PLAN PAYS NON-NETWORK PROVIDERS** |
| **Prosthetics** Pre-authorization is required for certain prosthetics | 90% after deductible | 70% after deductible |
| **Rehabilitation –** includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary | 90% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic | 70% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic |
| **Sex Change / Transgender Surgical Procedures -** Pre-authorization is required. | 90% 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% after deductible; $10,000 maximum per surgery or series of surgeries | |
| **Skilled Nursing Facility –** the facility's semiprivate room rate. Pre-authorization is required. | 90% after deductible; 100 days Plan Year maximum | 70% after deductible; 100 days Plan Year maximum |
| **Speech Therapy** | 90% after deductible | 70% after deductible |
| **Spinal Manipulation / Chiropractic** | 90% after deductible; 24 visits Plan Year maximum combined with Rehabilitation | 70% after deductible; 24 visits Plan Year maximum combined with Rehabilitation |
| **Substance Abuse** | | |
| Inpatient - the facility's semiprivate room rate. Pre- authorization is required. | 90% after deductible | 70% after deductible |
| Outpatient - Pre-authorization is required for certain services. | 90% after deductible | 70% after deductible |
| Office Setting | 90% after deductible | 70% after deductible |
| **Urgent Care –** includes physician services | 90% after deductible | 90% after deductible |
| **Voluntary Sterilization** | | |
| Female | 100%; deductible waived | 70% after deductible |
| Male | 90% after deductible | 70% after deductible |
| **Wigs –** after chemotherapy | 90% after deductible | 70% after deductible |