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: • Cost containment penalties • Amounts over the Maximum Allowable Amount • 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; 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; $3,000 maximum per surgery	
Blood	100% after deductible	Not covered
Diabetes Education	100% after $25 copayment; deductible waived	Not covered

SUMMARY OF BENEFITS EPO 250		
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 $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	100% after deductible $2,500 maximum per ear every 36 months 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; 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

SUMMARY OF BENEFITS EPO 250		
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; $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; $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; 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 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; 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.

SUMMARY OF BENEFITS EPO 250		
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		
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%: • Charges for Medical Services • 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.	100% after $150 copayment	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.