## PLAN DESIGN & BENEFITS

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Deductible** (per calendar year) | $500 Individual<br>$1,000 Family | $1,000 Individual<br>$2,000 Family |
| All covered expenses accumulate separately toward the preferred or non-preferred Deductible.<br>Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses do not apply towards the Deductible.<br>The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount. | | |
| **Member Coinsurance**<br>Applies to all expenses unless otherwise stated. | 20% | 50% |
| **Member Coinsurance Limit** | $1,500 Individual<br>$3,000 Family | $4,000 Individual<br>$8,000 Family |
| **Member Copay Maximum** | $4,600 Individual<br>$9,200 Family | $7,700 Individual<br>$15,400 Family |
| **Member Payment Limit** (per calendar year) | $6,600 Individual<br>$13,200 Family | $12,700 Individual<br>$25,400 Family |
| All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.<br>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.<br>Pharmacy expenses apply towards the Payment Limit.<br>The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount. | | |
| **Lifetime Maximum**<br>Unlimited except where otherwise indicated. | | |
| **Primary Care Physician Selection** | Optional | Not Applicable |
| **Certification Requirements -**<br>Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care.<br>Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence. | | |
| **Referral Requirement** | None | None |
| **PREVENTIVE CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Routine Adult Physical Exams/ Immunizations** | Covered 100%; deductible waived | Not Covered |
| 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older. | | |
| **Routine Well Child Exams/Immunizations** | Covered 100%; deductible waived | Not Covered |
| 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22. | | |
| **Routine Gynecological Care Exams** | Covered 100%; deductible waived | Not Covered |
| Recommended: One exam per calendar year. Includes routine tests and related lab fees. | | |
| **Routine Mammograms** | Covered 100%; deductible waived | Not Covered |

## PLAN DESIGN & BENEFITS

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| **Women's Health** | Covered 100%; deductible waived | Not Covered |
| Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | | |
| **Routine Digital Rectal Exam** | Covered 100%; deductible waived | Not Covered |
| Recommended: For covered males age 40 and over. | | |
| **Prostate-specific Antigen Test** | Covered 100%; deductible waived | Not Covered |
| Recommended: For covered males age 40 and over. | | |
| **Colorectal Cancer Screening** | Covered 100%; deductible waived | Not Covered |
| Recommended: For all members age 50 and over. | | |
| **Routine Eye Exams** | Covered 100%; deductible waived | Not Covered |
| 1 routine exam per 24 months. | | |
| **Routine Hearing Screening** | Covered 100%; deductible waived | Not Covered |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Office Visits to Non-Specialist** | $25 copay; deductible waived | 50%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Teledoc™** | $0 per consultation | Not Applicable |
| Teladoc is available for minor acute, episodic illnesses or when your primary care physician is not available. Teladoc's U.S. board-certified doctors can resolve many of your medical issues, 24/7/365, via phone 1-855-Teladoc (835-2362); or online video consults from wherever you happen to be. Teladoc may not be available in certain states and service limitations may apply (e.g., limited telephonic services for pharmacy in California). | | |
| **Specialist Office Visits** | $25 copay; deductible waived | 50%; after deductible |
| **Audiometric Hearing Exam** | Not Covered | Not Covered |
| **Pre-Natal Maternity** | Covered 100%; deductible waived | Covered according to standard claim practice. |
| **Walk-in Clinics** | $25 copay; deductible waived | 50%; after deductible |
| Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic. | | |
| **Allergy Testing** | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| **Allergy Injections** | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Diagnostic X-ray** | 20%; after deductible | 50%; after deductible |
| (other than Complex Imaging Services)<br>If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **Diagnostic Laboratory** | 20%; after deductible | 50%; after deductible |
| If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **Diagnostic Complex Imaging** | 20%; after deductible | 50%; after deductible |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Urgent Care Provider** | $50 copay; deductible waived | 50%; after deductible |

**PLAN DESIGN & BENEFITS**

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| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |
| **Emergency Room**<br>Copay waived if admitted | $100 copay; deductible waived | Same as in-network care |
| **Non-Emergency Care in an Emergency Room** | Not Covered | Not Covered |
| **Emergency Use of Ambulance** | 20%; after deductible | Same as in-network care |
| **Non-Emergency Use of Ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient Coverage**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 50%; after deductible |
| **Inpatient Maternity Coverage**<br>(includes delivery and postpartum care)<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 50%; after deductible |
| **Outpatient Hospital Expenses**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 50%; after deductible |
| **Outpatient Surgery - Hospital**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 50%; after deductible |
| **Outpatient Surgery - Freestanding Facility**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 50%; after deductible |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 50%; after deductible |
| **Outpatient**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | $25 copay; deductible waived | 50%; after deductible |
| **SUBSTANCE ABUSE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 50%; after deductible |
| **Residential Treatment Facility** | 20%; after deductible | 50%; after deductible |
| **Outpatient**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | $25 copay; deductible waived | 50%; after deductible |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled Nursing Facility**<br>Limited to 120 days per calendar year.<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 20%; after deductible |
| **Home Health Care** | 20%; after deductible | 20%; after deductible |
| **Hospice Care - Inpatient**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | Covered 100%; deductible waived | Covered 100%; deductible waived |
| **Hospice Care - Outpatient**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | Covered 100%; deductible waived | Covered 100%; deductible waived |
| **Private Duty Nursing** | 50%; after deductible | 50%; after deductible |
| **Outpatient Short-Term Rehabilitation**<br>Includes speech, physical, occupational therapy; limited to 60 visits per calendar year | 20%; after deductible | 50%; after deductible |
| **Spinal Manipulation Therapy**<br>Limited to 24 visits per calendar year. | $25 copay; deductible waived | 50%; after deductible |

**PLAN DESIGN & BENEFITS**

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| **Autism Behavioral Therapy**<br>Combined with outpatient mental health visits | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| **Autism Applied Behavior Analysis** | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| **Autism Physical Therapy**<br>Visits combined with Short Term Rehabilitation. | 20%; after deductible | 50%; after deductible |
| **Autism Occupational Therapy**<br>Visits combined with Short Term Rehabilitation. | 20%; after deductible | 50%; after deductible |
| **Autism Speech Therapy**<br>Visits combined with Short Term Rehabilitation. | 20%; after deductible | 50%; after deductible |
| **Durable Medical Equipment** | 20%; after deductible | 20%; after deductible |
| **Orthotics** | 20%; after deductible | 50%; after deductible |
| **Diabetic Supplies** | Covered same as any other medical expense. | Covered same as any other medical expense. |
| **Affordable Care Act mandated Women's Contraceptives** | Covered 100%; deductible waived | Covered same as any other expense. |
| **Women's Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; deductible waived | Covered same as any other medical expense. |
| **Vision Eyewear** | Not Covered | Not Covered |
| **Transplants** | 20%; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. | 50%; after deductible<br>Non-Preferred coverage is provided at a Non-IOE facility. |
| **Bariatric Surgery** | 20%; after deductible | 50%; after deductible |
| **FAMILY PLANNING** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Infertility Treatment**<br>Diagnosis and treatment of the underlying medical condition only. | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| **Comprehensive Infertility Services**<br>Artificial insemination and ovulation induction | 20%; after deductible | 50%; after deductible |
| **Advanced Reproductive Technology (ART)**<br>In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery. One attempt per lifetime | Not Covered | Not Covered |
| **Vasectomy** | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| **Tubal Ligation** | Covered 100%; deductible waived | Your cost sharing is based on the type of service and where it is performed |

## PLAN DESIGN & BENEFITS

| PHARMACY | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Generic Drugs** | | |
| **Retail** | $15 copay | 20% of submitted cost; after applicable copay |
| **Mail Order** | $30 copay | Not Applicable |
| **Preferred Brand-Name Drugs** | | |
| **Retail** | $40 copay | 20% of submitted cost; after applicable copay |
| **Mail Order** | $80 copay | Not Applicable |
| **Non-Preferred Brand-Name Drugs** | | |
| **Retail** | $80 copay | 20% of submitted cost; after applicable copay |
| **Mail Order** | $160 copay | Not Applicable |
| **Specialty Drugs** | | |
| **Preferred Specialty** | 20%<br>Maximum $400 | Not Applicable |
| **Non-Preferred Specialty** | 20%<br>Maximum $400 | Not Applicable |
| **Pharmacy Day Supply and Requirements** | | |
| **Retail** | Up to a 90 day supply | |
| **Mail Order** | Up to a 31-90 day supply | |
| **Specialty** | Up to a 30 day supply Pharmacy | |

**Choose Generics with Dispense as Written (DAW) override** - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

**Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Performance Enhancing Drugs limited to 8 tablets per month.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
Pre-certification for Specialty Drugs
Step Therapy included
One transition fill allowed within 90 days of member's effective date.
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

## GENERAL PROVISIONS

**Dependents Eligibility**

Spouse, children from birth to age 26 regardless of student status.
While this material is believed to be accurate as of the production date, it is subject to change.
Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design purchased by your employer.

**PLAN DESIGN & BENEFITS**

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.