PLAN MAXIMUMS AND LIMITATIONS			
Lifetime Benefit	Unlimited		
Calendar Year Benefit	Unlimited		
Skilled Nursing Facility	30 days per Calendar Year		
Chiropractic Care	10 visits per Calendar year		
Bras *(made solely for use with an external breast prosthesis)*	2 every 12 months		
Colonoscopy Screening *(Participants age 50 years or older; or any Participant at high risk – screening deemed Medically Necessary*	1 screening every 2 years $1,500 maximum every 2 years; applicable to Non-PHO and Non-PPO Providers only		
Mammograms	Age 35 – 39; 1 screening every 2 years Age 40 and over – 1 screening each Calendar Year		
CALENDAR YEAR DEDUCTIBLE	**PHO**	**Network**	**Non-Network**
Individual	$500	$3,500	$7,500
Family (cumulative)	$1,500	$7,500	$13,000
The Calendar Year Deductible applies to all expenses unless otherwise indicated. *Amounts applied to the PHO or Network Calendar Year Deductible will not apply to the Non-Network Calendar Year Deductible, and vice-versa. However, amounts applied to the PHO Calendar Year Deductible will apply to the Network Calendar Year Deductible, and vice versa.*			
OUT-OF-POCKET MAXIMUM	**PHO**	**Network**	**Non-Network**
Individual	$1,500	$6,500	Unlimited
Family (cumulative)	$4,500	$13,500	Unlimited
The PHO and Network Calendar Year Deductible apply to the PHO and Network Out-of-Pocket Maximum. *Amounts applied to the PHO Out-of-Pocket Maximum will also apply to the Network Out-of-Pocket Maximum, and vice-versa.*			
BENEFIT PERCENTAGES	**PHO**	**Network**	**Non-Network**
Inpatient Hospital Expenses			
Facility Fees	85%*	75%*	$300 per Admission copay; 50%
Professional Fees	85%*	75%*	50%
**Until the Out-of-Pocket Maximum has been reached, then Covered Expenses are payable at 100% for the remainder of the Calendar Year.*			

BENEFIT PERCENTAGES	**PHO**	**Network**	**Non-Network**
Outpatient Hospital Expenses *(facility and professional fees)*	85%*	75%*	50%
Emergency Room Expenses			
Emergency Use *(facility and professional fees)*	100% (1)	100% (1)	100% (1)
Non-Emergency Use (*facility and professional fees))*	85%*	75%*	50%
Urgent Care Facility Expenses	85%*	75%*	50%
Ambulance Expenses	85%*	85%*	85%* (2)
Private Duty Nursing Expenses	85%*	75%*	50%
Skilled Nursing Facility Expenses	85%*	75%*	50%
Birthing Center Expenses	85%*	75%*	50%
Hospice Care Expenses	85%*	75%*	50%
Home Health Care Expenses	85%*	75%*	50%
Inpatient Rehabilitation Expenses	85%*	75%*	50%
Physician Office Visit Expenses			
Office Visit	$20 per visit copay (1) (3); 100%	$35 per visit copay (1) (3); 100%	50%
All Other Office Services	85%*	75%*	50%
Telemedicine Expenses *(for non-Emergency conditions)*	$20 per visit copay (1) (3); 100%	$35 per visit copay (1) (3); 100%	50%
Chiropractic Care Expenses	50%*	50%*	50%
Outpatient Occupational, Physical and Speech Therapy Expenses	85%*	75%*	50%
Independent Diagnostic, X-ray and Lab Facility Expenses	85%*	75%*	50%
Durable Medical Equipment and Supply Expenses	85%*	75%*	50%

(1) The Calendar Year Deductible is waived.

(2) Expenses are subject to the Network Calendar Year Deductible and Out-of-Pocket Maximum.

(3) Copays apply to the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been reached, no further copays apply for the remainder of the Calendar Year.

**Until the Out-of-Pocket Maximum has been reached, then Covered Expenses are payable at 100% for the remainder of the Calendar Year.*

BENEFIT PERCENTAGES	PHO	Network	Non-Network
Nutritional Counseling/Education Expenses Related to Gestational, Type I or Type II Diabetes, Hyperlipidemia and High Cholesterol	85%*	85%*	85%
Organ Transplant Expenses	75%*	75%*	Not Covered
Outpatient Dialysis Services	100% (after satisfaction of Deductible). For the first four (4) months for Outpatient dialysis services rendered by PHO/Network health care Providers, Covered Expenses will include the billed amount minus any discounts. For Outpatient dialysis services rendered by Non- Network health care Providers, Covered Expenses will include the billed amount. After the first four (4) months, Covered Expenses for Outpatient dialysis services rendered by both PHO/Network and Non-Network health care Providers will be paid at 125% of Medicare payment rates and guidelines in effect at the time services are Incurred for the geographical area in which the services are Incurred. Payment is based solely on the current year Medicare fee schedule and not on the Maximum Allowable Charge.		
Temporomandibular Joint Disorder Expenses	50%	50%	50%
Preventive Care Expenses	100% (1)	100% (1)	50% to $125 (1); then Deductible, 50%
Testing for the 2019 Novel Coronavirus (COVID-19) including Telehealth and Other Communication-Based Technology Services	100 (1)	100 (1)	100 (1)
All Other Covered Expenses	85%*	75%*	50%

(1) The Calendar Year Deductible is waived.

**Until the Out-of-Pocket Maximum has been reached, then Covered Expenses are payable at 100% for the remainder of the Calendar Year.*

PRESCRIPTION DRUG BENEFIT		
TRADITIONAL RX PLAN - provided by HealthSmart Rx		
Calendar Year Maximum Out of Pocket (includes Calendar Year Deductible)	$2,000 per person	
Calendar Year Deductible	$100 per person *(brand name only)*	
Retail Pharmacy Option: 34-day supply or less (90-day for maintenance medications only)		
Generic Copayment, per prescription or refill	$5	
Brand with no Generic equivalent Copayment, per prescription or refill	$50 or 20%; whichever is greater	
Brand with Generic equivalent Copayment, per prescription or refill	Excluded	
Specialty medication,30-day supply per prescription or refill	20% up to $300 Copayment	
Diabetic Supplies *including lancets*	$0 Copayment *(Deductible waived)*	
Diabetic Medications		
Generic Copayment, per prescription or refill	34-day supply 35 to 60-day supply 61 to 90-day supply	$5 $10 $15
Brand with no Generic equivalent Copayment, per prescription or refill	30-day supply 31 to 60-day supply 61 to 90-day supply	$50 $100 $150
Brand with Generic equivalent Copayment, per prescription or refill	Excluded	

Specialty medications require prior authorization. Contact HealthSmart Rx at (800) 681-6912.

The Copays listed above will apply to the Prescription Plan's Out-of-Pocket Expense. Once this Out-of-Pocket Expense has been reached, covered prescriptions will be reimbursed at 100% for the remainder of the Calendar Year.

If a Participant purchases a Brand Name Drug when a Generic Drug is available and allowed by the Physician, in addition to the Brand copay, the Participant will also be responsible for the difference in cost between the Brand Name and Generic Drug.

Mail order not available.

MEC RX PLAN – provided by HealthSmart Rx	
Generic Copayment, per prescription or refill	$0
Brand Copayment, per prescription or refill	$0
Non-Formulary Brand Copayment, per prescription or refill	$0

Coverage is provided only for contraceptives and all other prescribed medications as defined by the Patient Protection and Affordable Care Act (PPACA).

Prescriptions or refills are limited to a 30-day maximum. Mail order not available.