SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out of pocket and/or Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Network and Non-Network Provider Arrangement

The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    a. The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as 50 miles.
    b. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out-of-Area or at a Non-Network Hospital for an Accident Bodily Injury or Emergency.

2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Network Provider Information

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

If the Participant does not have access to a computer at his or her home, he or she may access this website at his or her place of employment. If he or she has any questions about how to do this, he or she should contact the Human Relations Department. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the website address.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Covered Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 90 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

Transition of Care

If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

Calendar Year Maximum Benefit (Applies to All Plan Options)

The following Calendar Year maximums apply to each Participant.

Calendar Year Maximum Benefits for:	
All Essential Health Benefits	Unlimited

Summary of Benefits – Medical – Gold 200

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

	Network Providers	All Other Providers
Calendar Year Deductible		
Per person	$1,000	$2,500
Per family	$2,000	$5,000
Family is combined for all members		
*****IMPORTANT***** **THE DEDUCTIBLES FOR NETWORK AND ALL OTHER PROVIDERS ARE COMBINED. THE DEDUCTIBLE WILL BE WAIVED FOR ALL SERVICES WITH A COPAYMENT, UNLESS OTHERWISE SPECIFIED.**		
Maximum eligible out-of-pocket expense ***(includes the deductible, Medical copays and Prescription Drug copays)***		
Per person	$3,500	$7,000
Per family	$7,000	$14,000
Note: The Maximum Out-Of-Pocket Expense For Network And All other Providers Is Combined.		

The following table identifies what does and does not apply toward the Network and All Other Provider Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the All Other Providers Out-of-Pocket Maximum?
Payments toward the **annual** Deductible	**Yes**	**Yes**
Coinsurance payments**, even those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum**	**Yes**	**Yes**
Copayments	**Yes**	**Yes**
Charges for non-covered services	**No**	**No**
The amounts of any Pre-Certification penalties	**No**	**No**
Charges that exceed Allowable Expenses	**No**	**No**

	Network Providers	All Other Providers
Acupuncture	Not Covered	
Advanced Imaging Includes – Computed Tomographic (CT), studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans	20% after deductible	50% after deductible
Allergy Testing & Treatment Copayment per Visit	$40 Copay	50% after deductible N/A
Ambulance Services (Ground Water)	20% after deductible	50% after deductible
Ambulance Services (Air) Note: Maximum allowable charge defined in Medical Benefits Section of Plan	20% after deductible	50% after deductible
Ambulatory Surgical Center	20% after deductible	50% after deductible
Anesthesia	20% after deductible	50% after deductible
Behavioral Health Disorders Behavioral health refers to all behaviors that impact health. Mental health and substance use disorders are a very small, but attention getting subset of behavioral health, which includes behaviors related to obesity, diabetes, heart disease, HIV, ebola, malaria, tuberculosis, and other diseases.	$40 Copay	50% after deductible
Birthing Center	20% after deductible	50% after deductible

	Network Providers	All Other Providers
Chemotherapy & Radiation Therapy		
Inpatient Services	20% after deductible	50% after deductible
Outpatient Services	20% after deductible	50% after deductible
Physician's Office	20% after deductible	50% after deductible
Chiropractic Services *(Including diagnostics performed by or in a chiropractic facility)*	$40 Copay	50% after deductible
Copayment per Visit		N/A
Clinical Trials (Patient Costs)	20% after deductible	50% after deductible
Diagnostic Testing, X-ray & Lab		
Inpatient Services	20% after deductible	50% after deductible
Outpatient Services	20% after deductible	50% after deductible
Physician's Office (those services billed on the same bill as the office visit charge or from a standalone diagnostic clinic or lab with the same date of service as the office visit– only one copay applies per visit)	20% after deductible	50% after deductible
Standalone Diagnostic Clinics and Laboratories – Quest Diagnostics	100% covered through Quest	50% after deductible
Standalone Diagnostic Clinics and Laboratories – All Other	20% after deductible	50% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible
Emergency Room - Hospital & Physician Services	$300 Copay	$300 Copay
Copayment per Visit *(waived if admitted directly to hospital from ER)*		
Habilitative Services		
Applied Behavior Analysis (ABA) Therapy	Not Covered	Not Covered
Occupational Therapy	20% after deductible	50% after deductible
Copayment per Visit	N/A	N/A
Physical Therapy	20% after deductible	50% after deductible
Copayment per Visit	N/A	N/A
Speech-Language Pathology	20% after deductible	50% after deductible
Hearing Aids	Not Covered	
Home Health Care	20% after deductible	50% after deductible
Hospice Care – Inpatient/Outpatient Services	20% after deductible	50% after deductible

	Network Providers	All Other Providers
Hospital Services – Inpatient Daily Room and Board limited to the average semiprivate room rate. Intensive Care Unit limited to Hospital's ICU charge.	20% after deductible	50% after deductible
Hospital Services – Outpatient	20% after deductible	50% after deductible
Infertility Services	Not Covered	
Injury to or Care of Mouth, Teeth and Gums Coverage includes certain dental services under the medical benefits; please see section entitled "Injury to or Care of Mouth, Teeth and Gums" under the "MEDICAL BENEFITS" section.	20% after deductible	50% after deductible
Massage Therapy	Not Covered	
Maternity Care Covered for Employee, Spouse & Dependent Daughter **Note:** In accordance with the Pregnancy Discrimination Act, maternity care benefits must be covered the same as any other sickness or better.	20% after deductible	50% after deductible
Organ Transplants Organ and tissue transplants are covered except those, which are classified as "Experimental and/or Investigational."	20% after deductible	50% after deductible
Orthotics	Not Covered	Not Covered
Outpatient Private Duty Nursing	20% after deductible	50% after deductible
Physician Office Services Copayment per Visit – Primary Care Provider (PCP) Copayment per Visit – Specialist ***Note:*** *For purposes of this Plan, Physicians considered a Primary Care Physician (PCP) are: Family Practitioner, General Practitioner, Internist, Pediatrician, OB/Gyn, Office based nurse practitioners, physician assistants, licensed professional counselors, licensed certified professional counselors, certified chemical dependency counselors, or licensed clinical social workers. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is not required.*	\$15 Copay \$40 Copay	50% after deductible 50% after deductible
Preadmission Testing (within 7 days of confinement)	20% after deductible	50% after deductible
	Network Providers	**All Other Providers**

Preventive Care Services	100%, deductible & copayment waived	50% after deductible
Prosthetics	20% after deductible	50% after deductible
Routine Vision Exam *Note: 1 exam every 12 months*	100%, deductible waived	50% after deductible
Second Surgical Opinion	100% after copayment	50% after deductible
Copayment per Visit	$40	N/A
Skilled Nursing Facility	20% after deductible	50% after deductible
Substance Abuse Treatment	$40 Copay	50% after deductible
Surgery Includes surgeon, assistant surgeon and anesthesiologist services.		
Inpatient Services	20% after deductible	50% after deductible
Outpatient Services	20% after deductible	50% after deductible
Outpatient Surgery Facility	20% after deductible	50% after deductible
Surgery performed in Physician's Office	20% after deductible	50% after deductible
Teladoc Consultations	$15 Copay	50% after deductible
Temporomandibular Joint Syndrome (TMJ)	20% after deductible	50% after deductible
Therapy Services		
Autism Spectrum Disorder Treatment	Not Covered	Not Covered
Cardiac Therapy	20% after deductible	50% after deductible
Cognitive Therapy	20% after deductible	50% after deductible
Occupational Therapy	20% after deductible	50% after deductible
Copayment per Visit	N/A	N/A
Physical Therapy	20% after deductible	50% after deductible
Copayment per Visit	N/A	N/A
Respiration Therapy	20% after deductible	50% after deductible
Speech Therapy	20% after deductible	50% after deductible
Vision therapy	Not Covered	Not Covered
Urgent Care Facility A clinic, acute-care facility or walk-in clinic with urgent care hours or walk-in clinic hours providing treatment for urgent care.	$40 Copay	$40 Copay
All Other Covered Services	20% after deductible	50% after deductible

Summary of Benefits - Prescription Drug – Core Plan

The following benefits are per Participant:

Covered Prescription Drug Expenses:	Participating Pharmacy	Non-Participating Pharmacy
Pharmacy Option (34-Day Supply)		
Copayment, per Prescription		
Specialty Drugs	$200 Copay or 30% deductible whichever is greater	N/A
Brand Name Drugs – Non-Preferred	$75 Copay or 45% deductible whichever is greater	N/A
Brand Name Drugs – Preferred	$35 Copay or 25% deductible whichever is greater	N/A
Generic Drugs	0% after deductible	N/A
Mail Order Option (90-Day Supply)		
Copayment, per Prescription*		
Specialty Drugs	Not Covered	N/A
Brand Name Drugs – Non-Preferred	N/A	N/A
Brand Name Drugs – Preferred	N/A	N/A
Generic Drugs	Free	N/A