

## MEDICAL SCHEDULE OF BENEFITS – HDHP \$1350 PLAN 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR DEDUCTIBLE</b> (combined with Prescription Drug Card Deductible)		
Single	\$1,350	\$2,500
Family	\$2,700*	\$5,000*
*Note: If you have Family coverage, the Family Deductible must be satisfied before the Plan will pay any benefits.		
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card)		
Single	\$6,000	\$18,000
Family	\$12,000	\$28,000
<b>MEDICAL BENEFITS</b>		
<b>Allergy Serum &amp; Injections</b>	80% after Deductible	50% after Deductible
<b>Ambulance Services</b>		
Ground	80% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance	Deductible, then \$200 Copay per trip, then 80%	Paid at Participating Provider level of benefits
<b>Ambulatory Surgical Center</b>	80% after Deductible	50% after Deductible
<b>Anesthesiologist</b>	80% after Deductible	50% after Deductible
<b>Anti-Embolism Garments (e.g. Jobst)</b>	Deductible, then \$50 Copay per pair, then 80%	50% after Deductible
Calendar Year Maximum Benefit	3 pairs	
<b>Cardiac Rehab (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Chemotherapy (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Chiropractic Care/Spinal Manipulation</b>	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	20 visits	
<b>Diagnostic Testing, X-Ray and Lab Services (Outpatient)</b>	80% after Deductible	50% after Deductible
Oncotype Diagnostic Testing	80% after Deductible	50% after Deductible
<b>Durable Medical Equipment (DME)</b>	80% after Deductible	50% after Deductible

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<b>Emergency Services</b>		
Emergency Medical Condition		
Facility Charges	80% after Deductible	Paid at Participating Provider level of benefits
Professional Fees and Ancillary Charges	80% after Deductible	Paid at Participating Provider level of benefits
<b>Non-Emergency Medical Condition</b>		
Facility Charges	80% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	80% after Deductible	50% after Deductible
<b>Foot Orthotics</b>	80% after Deductible	50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months	
<b>Hearing Aids (including any office visit and any related services, includes cochlear Implants )</b>	80% after Deductible	50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
<b>Hemodialysis (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Home Health Care</b>	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits	
<b>Hospice Care</b>		
Inpatient	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
<b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</b>		
Inpatient	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	80% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.		
<b>Infusion Therapy in Facility or Physician's Office</b>	80% after Deductible	50% after Deductible
<b>Maternity (Professional Fees)*</b>		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		

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<b>Medical Supplies</b>	80% after Deductible	50% after Deductible
<b>Mental Disorders and Substance Use Disorders</b>		
Inpatient		
Facility Charge	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Professional Fees	80% after Deductible	50% after Deductible
Outpatient Facility	80% after Deductible	50% after Deductible
Office Visits	80% after Deductible	50% after Deductible
<b>NOTE:</b> Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
<b>Morbid Obesity (Surgical Treatment Only)</b>		
Facility	Deductible, then \$250 Copay, then 80%	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
<b>Nutritional Food Supplements</b>	50% after Deductible	50% after Deductible
<b>Occupational Therapy (Outpatient)</b>	80% after Deductible	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 visits	
<b>Physical Therapy (Outpatient)</b>	80% after Deductible	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 visits	
<b>Physician's Services</b>		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits	80% after Deductible	50% after Deductible
Physician Office Surgery	80% after Deductible	50% after Deductible
<b>Preventive Services and Routine Care</b>		
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% of the first \$300 per Calendar Year, then 10% (Deductible waived)	Not Covered
Flu Shots/Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	1 exam	
<b>NOTE:</b> Preventive prenatal and breastfeeding support are paid under the Maternity Benefit. Please see Maternity listed above for additional details.		

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<b>Prosthetics (other than bras)</b>	80% after Deductible	50% after Deductible
<b>Prosthetic Bras</b>	80% after Deductible	80% after Deductible
Calendar Year Maximum Benefit	2 bras	
<b>Psychological and Neuropsychological Testing</b>	50% after Deductible	50% after Deductible
<b>Radiation Therapy (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)</b>	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Calendar Year Maximum Benefit	60 days	
<b>Skilled Nursing Facility</b>	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Maximum Benefit per 12 Month Period	60 days	
<b>Speech Therapy (Outpatient)</b>	80% after Deductible	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 visits	
<b>Surgery (Inpatient)</b>		
Facility	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
<b>Surgery (Outpatient)</b>		
Facility	80% after Deductible	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
<b>Temporomandibular Joint Dysfunction (TMJ)</b>	Deductible, then \$50 Copay per occurrence, then 80%	50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance \$1,000	
<b>Transplants</b>		
Facility Services	Deductible, then \$250 Copay per admission, then 80%	Not Covered
Professional Fees	80% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% after Deductible.		
<b>NOTE:</b> Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other illness.		

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<b>Urgent Care Facility</b>	Deductible, then \$50 Copay per visit, then 80%	50% after Deductible
<b>Wig (see Eligible Medical Expenses)</b>	Deductible, then \$50 Copay per wig, then 80%	Deductible, then \$50 Copay per wig, then 80%
Maximum Benefit	1 every 24 months	
<b>All Other Eligible Medical Expenses</b>	Deductible, then \$50 Copay per occurrence, then 80%	50% after Deductible

## PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP \$1350 PLAN 2018-2019

BENEFIT DESCRIPTION	BENEFIT
<b>NOTE:</b> There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.	
<b>CALENDAR YEAR DEDUCTIBLE</b> (combined with major medical Deductible) Single Family	\$1,350 \$2,700*
*Note: If you have Family coverage, the Family Deductible must be satisfied before the Plan will pay any benefits.	
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</b> (includes Deductible and Coinsurance – combined with major medical) Single Family	\$6,000 \$12,000
<b>Retail Pharmacy: 30-day supply</b>	
Generic Drug	80% after Deductible
Preferred Drug	80% after Deductible
Non-Preferred Drug	80% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)
<b>Mail Order: 90-day supply</b>	
Generic Drug	80% after Deductible
Preferred Drug	80% after Deductible
Non-Preferred Drug	80% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)

### **Mandatory Generic Program**

The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

### **Mandatory Mail Order Program**

This plan will allow maintenance medications to be filled at retail in 30 day quantities only. For members who would like to purchase a 90 day supply of maintenance medications, the mail order option must be chosen, which could result in additional cost savings.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.