Schedule of Benefits

Notes:

- Copayments (Copay) - The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider. Copayments do not count towards any Deductible.
- This Summary Plan Description (SPD) does not provide coverage when you use an Out-of-Network Provider, except for an Emergency.
- Some benefits may require Preauthorization. Please check your Summary Plan Description for details.
- Please read the entire Summary Plan Description for other Covered Services, Benefits, Exclusions & Limitations.
- Benefits are applied per Calendar Year.
- The Summary Plan Description (SPD) does not cover Dental Care, Cosmetic Surgery, Long Term Care, or Non-Emergency Care when traveling outside the United States.
- In-Network benefits are paid based on the Negotiated Rate.
- The Emergency Room service Copayment does not count towards satisfying the Deductible.

2024 Schedule of Benefits – Select 4000 HSA HMO		
Annual	**Participating Provider (In-Network)**	**Non-Participating Provider (Out-of-Network)**
Individual Deductible:	$4,000	N/A
Family Deductible:	$8,000	N/A
Individual Out-of-Pocket Maximum:	$6,300	N/A
Family Out-of-Pocket Maximum:	$12,600	N/A
Coinsurance:	20%	N/A
Payment Order:	Copayment applies first, then Deductible, then Coinsurance (if applicable). These cost shares apply toward the Maximum Out-of-Pocket amount.	

Schedule of Benefits				
Medical Event & Professional Services	**Services You May Need**	**Participating Provider (In-Network)**	**Non-Participating Provider (Out-of-Network)**	**Exclusions & Limitations**
Primary Care Office Visits *Also Applies to Walk-in Clinics	Primary (PCP) Care Visit to Treat an Illness or Injury	20% Coinsurance Deductible applies first	Not Covered	
	Specialist Visit	20% Coinsurance Deductible applies first	Not Covered	
	Other practitioner office visit (e.g., Nurse, Physician Assistant)	20% Coinsurance Deductible applies first	Not Covered	
	Preventive Care, Screenings & Immunizations	No Charge Deductible does not apply	Not Covered	You may have to pay for services that aren't preventative. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For Children under the age of 6: Required immunizations are not subject to deductible, copayment or coinsurance requirements for Participating or Non-Participating Providers.
If you have a test	Diagnostic tests – Outpatient Lab and Professional Services	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required for all Genetic Testing and Complex Imaging.
	Diagnostic tests – X-Rays and Diagnostic Imaging	20% Coinsurance Deductible applies first	Not Covered	
	Imaging (CT/PET Scans, MRIs)	20% Coinsurance Deductible applies first	Not Covered	

If you need immediate medical attention	Emergency Medical Transportation	20% Coinsurance Deductible applies first	No Charge Deductible applies first	
	Emergency Room Services	20% Coinsurance Deductible applies first	No Charge Deductible applies first	
	Urgent Care	20% Coinsurance Deductible applies first	No Charge Deductible applies first	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required.
	Physician/surgeon fees	20% Coinsurance Deductible applies first	Not Covered	In-network: Cost included in Inpatient stay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required.
	Physician/surgeon fees	20% Coinsurance Deductible applies first	Not Covered	
If you have mental health, behavioral health, or substance abuse services	Professional Office Visits	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required for MH/SA intensive (extended) or residential services, Applied Behavioral Analysis (ABA) therapy and non-behavioral health providers neuropsychiatric testing.
	Outpatient Services	20% Coinsurance Deductible applies first	Not Covered	
	Inpatient Services	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required.
If you are pregnant	Office Visits	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required only for the period outside the 48/96-hour timeframe listed in the Certificate of Coverage. Childbirth/delivery professional services: Cost included in Inpatient stay.
	Childbirth/delivery professional services	20% Coinsurance Deductible applies first	Not Covered	
	Childbirth/delivery facility services	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required.

Oral Contraceptives & Contraceptive services and devices	All FDA approved devices - Educational services & counseling	No Charge Deductible does not apply	Not Covered	Not subject to Copayment for Generic or Brand Name Formulary Drugs, if Generic Drug not available.
If you need help recovering or have special health needs	Home Health Care	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required. Limited to 60 visits per year.
	Skilled Nursing care	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required. Limited to 25 days per year.
	Prosthetic & Orthotic devices (Appliances)	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required.
	Durable Medical Equipment	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required for items exceeding $500.
	Hospice Service	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required.
Rehabilitative & Habilitative Services and Devices	Hearing Aids & Cochlear Implants	20% Coinsurance Deductible applies first	Not Covered	Hearing Aids & Cochlear Implants limited to 1 pair OR one implant every 36 months.
	Outpatient Rehabilitation Services	20% Coinsurance Deductible applies first	Not Covered	PT/OT/ST: Limited to 35 visits per service per plan year. Plan limitations do not apply to medically necessary services or services related to Autism Spectrum Disorder. Preauthorization required for Inpatient & ABA in Cognitive Therapy Cardio/Pulmonary Rehabilitation limited to 36 visits for Cardiac Rehab and 36 visits for Pulmonary Rehab.
	Outpatient Habilitation Services	20% Coinsurance Deductible applies first	Not Covered	
	Physical Therapy & Occupational Therapy & Speech Therapy	20% Coinsurance Deductible applies first	Not Covered	
	Chiropractic Care	20% Coinsurance Deductible applies first	Not Covered	Limited to 35 visits per plan year.
	Speech & Hearing Exams	20% Coinsurance Deductible applies first	Not Covered	

Other Professional Services	Radiation & Chemotherapy	20% Coinsurance Deductible applies first	Not Covered	
	Infusion Therapy	20% Coinsurance Deductible applies first	Not Covered	
	Transplant	20% Coinsurance Deductible applies first	Not Covered	Preauthorization required.
	Routine Foot Care	20% Coinsurance Deductible applies first	Not Covered	
	Allergy Testing	20% Coinsurance Deductible applies first	Not Covered	
	Dialysis	20% Coinsurance Deductible applies first	Not Covered	
	Telehealth or Telemedicine Services	$45 Copay Deductible does not apply	Not Covered	Copayment, Coinsurance, and Deductible amounts will not exceed amount for comparable medical services provided through a face-to-face consultation.

Pharmacy Schedule of Benefits				
		Participating Provider (In-Network)	**Non-Participating Provider (Out-of-Network)**	**Exclusions & Limitations**
30 Day Retail Pharmacy Service	Tier 1: Low cost, high value Generics and select Brands	Preferred: $2 Copay Non-Preferred: $8 Copay Deductible applies first	Not Covered	
	Tier 2: Preferred Brands and select Generics	Preferred: $40 Copay Non-Preferred: $50 Copay Deductible applies first	Not Covered	
	Tier 3: Non-Preferred Brands and Generics	Preferred: $90 Copay Non-Preferred: $100 Copay Deductible applies first	Not Covered	
	Tier 4: Specialty Drugs	33% Coinsurance Deductible applies first	Not Covered	Specialty Drugs are subject to Utilization Review.
	Tier 5: Medical Drugs	Refer to Health Plan for coverage	Not Covered	Drugs marked with 'M' on Formulary, covered under Medical
	Tier 6: Zero Cost-share, Preventive Drugs (All FDA-Approved Prescriptions)	$0 Copay Deductible does not apply	Not Covered	Not subject to Copayment for Generic or Brand Name Formulary Drugs, if Generic Drug not available.
90 Day Mail Service	Tier 1: Low cost, high value Generics and select Brands	$4 Copay Deductible applies first	Not Covered	Some prescription drugs and/or medications are not available through the Mail Order Service.
	Tier 2: Preferred Brands and select Generics	$80 Copay Deductible applies first	Not Covered	
	Tier 3: Non-Preferred Brands and Generics	$180 Copay Deductible applies first	Not Covered	
	Tier 4: Specialty Drugs	Not Covered	Not Covered	
	Tier 5: Medical Drugs	Not Covered	Not Covered	
	Tier 6: Zero Cost-share, Preventive Drugs (All FDA-Approved Prescriptions)	$0 Copay Deductible does not apply	Not Covered	Not subject to Copayment for Generic or Brand Name Formulary Drugs, if Generic Drug not available.