# MEDICAL PLAN A+

| | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| **FINANCIAL** | | |
| **Lifetime Maximum:** | Unlimited | Unlimited |
| **Deductible:** Applies per calendar year; cross accumulates in and out of network; includes 4th quarter deductible carry-over | | |
| **Individual** | $100 | $100 |
| **Family** | $200 | $200 |
| **Out-of-Pocket Limit:** Per calendar year; cross accumulates in and out of network; includes deductible, coinsurance, and copayments | | |
| **Individual** | $1,600 | $3,100 |
| **Family** | $3,200 | $6,200 |
| **MEDICAL BENEFITS** | | |
| **Allowances based on:** | Contract Rate | Usual, Customary, and Reasonable (UC&R) |
| **Coinsurance:** | 10% after deductible | 30% after deductible |
| **Prior Authorization:** | Prior authorization required for all inpatient and many outpatient services, including prescription drugs | |
| **PREVENTIVE CARE** | | |
| **Routine Examinations** | Deductible waived - no copayment | Deductible waived - 30% coinsurance |
| | Annual physical, gyn exam, routine well child visits, related routine lab & x-rays, routine Immunizations | |
| **Routine Colonoscopy** | Deductible waived - no copayment | Deductible waived - 30% coinsurance |
| | Covered every 3 years from age 50; If high risk of colon cancer, every 2 years regardless of age | |
| **Routine Mammogram** | Deductible waived - no copayment | Deductible waived - 30% coinsurance |
| | 1 baseline covered between age 35-39; 1 routine mammogram covered per year from age 40 | |
| **PHYSICIAN SERVICES** | | |
| **Primary Care Office Visit** | $5 copayment per visit | 30% after deductible |
| **Specialist Office Visit** | $10 copayment per visit | 30% after deductible |
| **Emergency Room Physician Visit** | Facility copayment applies | Facility copayment applies if true emergency<br>30% after deductible if not a true emergency |
| **Inpatient Hospital Visit** | Facility copayment applies | 30% after deductible |
| **Urgent Care Physician** | Facility copayment applies | 30% after deductible |
| **Surgical Professionals** | Facility copayment applies | 30% after deductible |
| **HOSPITAL / URGENT CARE FACILITY SERVICES** | | |
| **Inpatient Hospital** | $75 copayment per admission | 30% after deductible |
| **Outpatient Hospital** | $50 copayment per visit | 30% after deductible |
| **Emergency Room** | $50 copayment per visit | $50 copayment per visit if true emergency<br>30% after deductible if not a true emergency |
| **Urgent Care Facility** | $25 copayment per visit | 30% after deductible |
| **OTHER SERVICES** | | |
| **Allergy Tests/Treatment** | Visit copayment applies | 30% after deductible |
| **Ambulance Transport** | 10% after deductible | 30% after deductible |
| **Ambulatory Surgery Ctr** | $50 copayment per visit | 30% after deductible |
| **Bariatric Surgery** | Facility copayment applies | Not covered |
| | In network only through CIGNA Centers of Excellence for Bariatric Surgery - No out of network coverage | |
| **Chemotherapy** | 10% after deductible | 30% after deductible |
| **Chiropractic Care** | $10 copayment per visit | 30% after deductible |
| | Maximum 20 days of chiropractic treatment per calendar year | |
| **Diagnostic Lab** | 10% after deductible | 30% after deductible |
| **Diagnostic X-Ray** | 10% after deductible | 30% after deductible |
| Coinsurance applies on charges from independent lab or x-ray facility. If done at a physician's visit, the office visit copayment applies. | | |

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| **OTHER SERVICES - *Continued*** | | |
| **Durable Medical Equipment (DME)** | 10% after deductible | 30% after deductible |
| | Rental benefit limited to purchase price (or contract rate) of medically necessary medical equipment | |
| **Hearing Aids** | 10% after deductible | 30% after deductible |
| **Home Health Care** | 10% after deductible | 30% after deductible |
| **Hospice Care** | 10% after deductible | 30% after deductible |
| **Organ Transplant** | Paid like any other illness based on the type of service that is received | |
| **Podiatry Treatment** | $10 copayment per visit | 30% after deductible |
| | Max 30 days treatment per calendar year. Limit does not apply to covered surgical procedures. | |
| **Prosthetics / Orthotics** | 10% after deductible | 30% after deductible |
| **Outpatient Rehabilitative Therapy** | $10 copayment per visit | 30% after deductible |
| | Max 50 days of treatment per calendar year for all therapies; physical, speech, occupational, cardiac, etc. | |
| **Radiation Therapy** | 10% after deductible | 30% after deductible |
| **Skilled Nursing Facility** | 10% after deductible | 30% after deductible |
| | Maximum 100 days of treatment per cal year | |
| **Vision Correction Surgery** | 10% after deductible | 30% after deductible |
| | Maximum benefit of $1,000 per eye and $2,000 lifetime | |
| **MENTAL HEALTH CARE** | | |
| **Inpatient** | $75 copayment per admission | 30% after deductible |
| **Outpatient Facility** | $50 copayment per visit | 30% after deductible |
| **Outpatient Visits** | $10 copayment per visit | 30% after deductible |
| **SUBSTANCE ABUSE TREATMENT** | | |
| **Inpatient** | $75 copayment per admission | 30% after deductible |
| **Outpatient Facility** | $50 copayment per visit | 30% after deductible |
| **Outpatient Visits** | $10 copayment per visit | 30% after deductible |

| **PRESCRIPTION DRUGS** | **CVS/caremark is the Pharmacy Benefit Manager** | |
|---|---|---|
| Program Includes generic step therapy, which requires generic or equivalent be tried before preferred or non-preferred brand is covered (unless brand is pre-authorized). No copayment or coinsurance is required for generic and single source brand female contraceptives. Prior authorization is required for compound drugs over $300, for all male androgens, and for all specialty drugs. Formulary exclusions apply, but excluded items may be considered with prior authorization of medical necessity. Separate out-of-pocket limit. | | |
| **Coverage Details** | | |
| **Deductible** | None | |
| **Out-of-Pocket Limit** (per calendar year) | **Individual:** $1,600<br>**Family:** $3,200 | |
| **Medication Type** | **34 Day Supply - All retail pharmacies** | **90 Day Supply - CVS retail and Mail-Order** |
| - Generic | $10 copayment per script | $20 copayment per script |
| - Preferred Brand | $20 copayment per script | $30 copayment per script |
| - Non-Preferred Brand | $30 copayment per script | $40 copayment per script |
| **Specialty Medications** - Require prior authorization and use of specialty pharmacy. Days supply and/or quantity dispensed will be based on type of medication, and dosage and handling requirements. | | |
| - All Specialty Meds | $40 copayment per script | |
| **AGE LIMIT FOR DEPENDENT CHILDREN** | | |
| Dependent children are covered to age 26. Coverage ends the last day of the month in which a child reaches age 26. | | |

This is a summary of benefits only. Coverage is subject to medical necessity (except preventive care) and may be subject to limitations and exclusions. Refer to the Summary Plan Description or contact the Benefit Trust Fund for information about limitations/exclusions.

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