# MEDICAL PLAN C

| | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| **FINANCIAL** | | |
| **Lifetime Maximum:** | Unlimited | Not covered |
| **Deductible:** This Plan has no deductible, only copayments | | |
| **Individual** | None | Not covered |
| **Family** | None | Not covered |
| **Out-of-Pocket Limit:** Per calendar year, includes copayments (Prescription Drug coverage has a separate out-of-pocket limit) | | |
| **Individual** | $6,000 | Not covered |
| **Family** | $12,000 | Not covered |
| **MEDICAL BENEFITS** | | |
| **Allowances based on:** | Contract Rate | N/A |
| **Coinsurance:** | 0% | N/A |
| **Prior Authorization:** | Prior authorization required for all inpatient and many outpatient services, including prescription drugs | |
| **PREVENTIVE CARE** | | |
| **Routine Examinations** | No copayment - Plan pays 100% | Not covered |
| | Annual physical, gyn exam, routine well child visits, related routine lab & x-rays, routine Immunizations | |
| **Routine Colonoscopy** | No copayment - Plan pays 100% | Not covered |
| | Covered every 3 years from age 50; If high risk of colon cancer, every 2 years regardless of age | |
| **Routine Mammogram** | No copayment - Plan pays 100% | Not covered |
| | 1 baseline covered between age 35-39; 1 routine mammogram covered per year from age 40 | |
| **PHYSICIAN SERVICES** | | |
| **Primary Care Office Visit** | $30 copayment per visit | Not covered |
| **Specialist Office Visit** | $50 copayment per visit | Not covered |
| **Emergency Room Physician Visit** | Facility copayment applies | Facility copayment applies if true emergency<br>Not covered if not a true emergency |
| **Inpatient Hospital Visit** | Facility copayment applies | Not covered |
| **Urgent Care Physician** | Facility copayment applies | Not covered |
| **Surgical Professionals** | Facility copayment applies | Not covered |
| **HOSPITAL / URGENT CARE FACILITY SERVICES** | | |
| **Inpatient Hospital** | $500 copayment per admission | Not covered |
| **Outpatient Hospital** | $200 copayment per visit | Not covered |
| **Emergency Room** | $200 copayment per visit | $200 copayment per visit if true emergency<br>Not covered by Plan if not a true emergency |
| **Urgent Care Facility** | $50 copayment per visit | Not covered |
| **OTHER SERVICES** | | |
| **Allergy Tests/Treatment** | Visit copayment applies | Not covered |
| **Ambulance Transport** | $100 copayment per event | Not covered |
| **Ambulatory Surgery Ctr** | $50 copayment per visit | Not covered |
| **Bariatric Surgery** | Facility copayment applies<br>Through CIGNA Centers of Excellence | Not covered |
| **Chemotherapy** | $200 copayment per visit | Not covered |
| **Chiropractic Care** | $50 copayment per visit<br>Maximum 20 days treatment per calendar year | Not covered |
| **Diagnostic Lab** | $20 copayment per visit | Not covered |
| **Diagnostic X-Ray** | $50 copayment per visit | Not covered |
| 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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| | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| **OTHER SERVICES** *- Continued* | | |
| **Durable Medical Equipment (DME)** | $50 copayment per item | Not covered |
| | Rental benefit limited to purchase price (or contract rate) of medically necessary medical equipment | |
| **Home Health Care** | $100 copayment per visit | Not covered |
| **Hospice Care** | $100 copayment per visit | Not covered |
| **Organ Transplant** | Paid like any other illness based on the type of service that is received | |
| **Podiatry Treatment** | $50 copayment per visit | Not covered |
| | Max 30 days treatment per calendar year. Limit does not apply to covered surgical procedures. | |
| **Prosthetics / Orthotics** | $50 copayment per item | Not covered |
| **Outpatient Rehabilitative Therapy** | $50 copayment per visit | Not covered |
| | Max 50 days of treatment per calendar year for all therapies; physical, speech, occupational, cardiac. etc. | |
| **Radiation Therapy** | $200 copayment per visit | Not covered |
| **Skilled Nursing Facility** | $200 copayment per stay | Not covered |
| | Maximum 100 days of treatment per cal year | |
| **MENTAL HEALTH CARE** | | |
| **Inpatient** | $500 copayment per admission | Not covered |
| **Outpatient Facility** | $200 copayment per visit | Not covered |
| **Outpatient Visits** | $50 copayment per visit | Not covered |
| **SUBSTANCE ABUSE TREATMENT** | | |
| **Inpatient** | $500 copayment per admission | Not covered |
| **Outpatient Facility** | $200 copayment per visit | Not covered |
| **Outpatient Visits** | $50 copayment per visit | Not covered |

| **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** | **Use of CVS network pharmacies is required - No coverage outside of CVS network** | |
| **Deductible** | None | |
| **Out-of-Pocket Limit** (per calendar year) | **Individual:** $1,900<br>**Family:** $3,800 | |
| **Medication Type** | **34 Day Supply - CVS network retail pharmacies** | **90 Day Supply - CVS retail and Mail-Order** |
| - Generic | $10 copay | $20 copay |
| - Preferred Brand | 20% up to $50 max | 20% up to $100 max |
| - Non-Preferred Brand | 30% up to $100 max | 30% up to $200 max |
| **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 | 20% up to $200 per script | |
| **AGE LIMIT FOR DEPENDENT CHILDREN** | | |
| Eligible 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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