Group Name
MEDICAL COVERAGE SUMMARY – HDHP 4

In-Network Providers will submit claims to TPA on the patient's behalf.
Out-of-Network claims must be filed no later than 12 months after the claim was incurred or the claim will be denied.

Submit Medical Claims to:

Electronic Claims Submission for Medical Claims: Payer ID # 62308
For a list of Preferred Providers
Submit Pharmacy Claims to: WellDyne; Members: 1-888-964-0039 Providers: 1-800-345-5413
Electronic Claims Submission for Pharmacy Claims: RxBIN:; PCN: ADV; Rx Grp:

Pre-Certification:

Inpatient Hospital admissions (including Mental Illness and Substance Abuse admissions); Skilled Nursing Facility and Rehabilitation Facility admissions; Hospice (Facility); Long Term Acute Care; Mental Health and Substance Abuse (inpatient, residential treatment center, partial hospitalizations, detoxification, and rehabilitation); Routine and high risk maternity (routine only if inpatient stay exceeds 48/96 hours); Diagnostic Radiology (CT scans, MRI/MRA, PET scans, etc.); Durable Medical Equipment (Seat Lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators, Home Health Care; Certain outpatient procedures; Transplants.

Pre-Certification Penalty: Services may be denied if Pre-Certification not obtained. The penalty will be assessed to the provider if the services are rendered by an in-network provider and Pre-Certification is not obtained. If services are rendered by an out-of-network provider, the penalty will be assessed to the Participant if Pre-Certification is not obtained.

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

Benefits and cost sharing accumulate on a Benefit Year basis from 1/1 through 12/31 each year.

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
DEDUCTIBLE	Per Benefit Year (Carryover does not apply) In-network and out-of-network deductibles are combined. The Deductible is embedded.	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
MEDICAL OUT-OF-POCKET MAXIMUM	Per Benefit Year (Carryover does not apply) Includes medical deductible, coinsurance, Copays and prescription drug out-of-pocket expenses. In-network and out-of-network Out-of-Pocket Maximums are combined. The Out-of-Pocket Maximum is embedded.	$6,750 Individual $13,500 Family	$15,000 Individual $30,000 Family
ANNUAL/LIFETIME MAXIMUM		Unlimited	

Radiologist, Anesthesiologists, Pathologists and Emergency Care: If you have a covered surgical procedure or inpatient stay at a Participating Hospital or facility, services by the associated physician, radiologist, anesthesiologist or pathologist, will be payable at the in-network benefit level. Emergency care and associated professional fees (E.g. anesthesiologist, pathologist, radiologist, etc.) rendered in a Hospital Emergency room will be payable at the in-network benefit level when rendered by either a non-preferred or Preferred Provider. The treatment must be for an Emergency as defined in the Plan. Follow-up care will be payable according to the Coverage Summary.

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ACUPUNCTURE		Not covered	Not covered
ALLERGY CARE			
-Office Visit		PCP: 80%, after deductible Copay per visit Specialist: 80%, after deductible Copay per visit	50% after deductible
-Treatment (Injections)		PCP: 80%, Specialist:80%	50% after deductible
-Serum		PCP: 80%, Specialist: 80%	50% after deductible
-Laboratory & Scratch Testing		PCP: 80%, Specialist: 80%	50% after deductible
AMBULANCE	Air ambulance and Ground Ambulance are covered if Medically Necessary. Non-emergency Ambulance is not covered.	80%	80%
ANESTHESIA			
-Inpatient		80%	50% after deductible
-Outpatient		80%	50% after deductible
-Office		80%	50% after deductible
APPLIED BEHAVIORAL ANALYSIS (ABA) THERAPY (For Autism Spectrum Disorders (ASD)	Maximum 150 visits. Subsequent visits during Benefit Year may be approved when Medically Necessary. ABA therapy is covered for the treatment of Autism Spectrum Disorders (ASD). Short-Term Therapy other than ABA therapy may be required for treatment of ASD.	80%	50% after deductible
AUTISM SPECTRUM DISORDERS	Covered when Medically Necessary.	Covered as described under type of service rendered	Covered as described under type of service rendered
BIOFEEDBACK		Not covered	Not covered
CARDIAC REHABILITATION	Covered when Medically Necessary in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery initiated within 12 weeks after other treatment for the medical condition ends.	80%, after deductible	50% after deductible

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CHEMOTHERAPY	Pre-Certification required for Therapeutic Radiology. Penalty listed above applies if not obtained. Benefit includes treatment with radioactive substances as well as materials and services of technicians.	80%, after deductible	50%, after deductible
CHIROPRACTOR	Maximum of 30 visits per Benefit Year	80%, after deductible	50%, after deductible
COLONOSCOPY			
-Routine Colonoscopy	Includes routine colonoscopy and related services, other than inpatient. Includes polyp removal during routine colonoscopy when billed properly by provider.	80%; deductible waived	50% after deductible
-Non-routine Colonoscopy	Includes colonoscopies and related services, other than routine, and other than inpatient.	80% after deductible	50% after deductible
DENTAL CARE COVERED UNDER MEDICAL PLAN	Routine care is not covered.		
-Accidental Injury to Teeth		Covered as described under type of service rendered	Covered as described under type of service rendered
-Dental Oral Surgery	Removal of wisdom teeth is covered Oral Surgeons will be paid at the In-Network benefit.	Covered as described under type of service rendered	Covered as described under type of service rendered
DIABETIC TREATMENT			
-Education		PCP: 80%, after deductible Copay per visit Specialist: 80%, after deductible Copay per visit	50% after deductible
-Supplies and Equipment	Refer to the Prescription Drug benefit for additional benefits available	80%	50% after deductible
DIAGNOSTIC X-RAYS AND IMAGING TESTS			
-Independent Facility		80%, after deductible	50% after deductible
-Outpatient Hospital		80%, after deductible	50% after deductible
-Physician's Office		PCP: 80% Specialist: 80%	50% after deductible
HIGH TECH IMAGING ***(SUCH AS MRI, MRA, PET AND CAT SCANS)***	Pre-Certification required on non-emergent imaging. Penalty listed above applies if not obtained.		
-Independent Facility		80%, after deductible	50% after deductible
-Outpatient Hospital		80%, after deductible	50% after deductible
-Physician's Office		80%, after deductible	50% after deductible

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DIALYSIS OR HEMODIALYSIS			
-Outpatient Hospital		80%	50% after deductible
-Office		80%	50% after deductible
-Any Other Place of Service		80% after deductible	50% after deductible
DURABLE MEDICAL EQUIPMENT (DME) ***Including, but not limited to:***	Pre-Certification required on DME. Penalty listed above applies if not obtained.		
-Durable Medical Equipment		80%	50% after deductible
-Disposable Medical Supplies		80%	50% after deductible
-Prosthetics (Internal)	Repair and replacement of a device will not be made more than once every 5 years, unless it is determined Medically Necessary. Replacements will not be made because the device is lost, misplaced, or stolen	80%	50% after deductible
-Prosthetics (External)		80%	50% after deductible
-Foot Orthotics	May be covered when Medically Necessary.	80%	50% after deductible
-Orthotics (Braces)		80%	50% after deductible
ENTERAL FORMULA		Not Covered	Not Covered
FAMILY PLANNING SERVICES			
-Elective Sterilization Procedures			
Tubal Ligation		80%	50% after deductible
Vasectomy	Reversal of voluntary sterilization is not covered.	Covered as described under type of service rendered	Covered as described under type of service rendered
-Contraceptive Devices		80%	50% after deductible
-Contraceptive Management Office Visit		80%	50% after deductible
-Infertility Treatment	Covers diagnostic services to determine the cause of Infertility. Treatment is not covered.	Not Covered	Not Covered

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GENDER REASSIGNMENT SERVICES	Pre-Certification required for surgery. Penalty listed above applies if not obtained. Covered when Medically Necessary. Maximum of $20,000 per lifetime for surgical treatment.	Covered as described under type of service rendered	Covered as described under type of service rendered
GENETIC TESTING AND COUNSELING	Covered when Medically Necessary.		
-Genetic Testing		80%	50% after deductible
-Genetic Counseling	Limited to 3 visits per Benefit Year.	80%, after deductible Copay per visit	50% after deductible
HEARING AIDS AND EXAMS	May be covered when required due to accidental injury or hearing loss is a result of a surgical procedure	Not Covered	Not Covered
HOME HEALTH CARE	Pre-Certification required. Penalty listed above applies if not obtained. Maximum of 60 visits per Benefit Year combined with Private Duty Nursing.	80%	50% after deductible
HOSPICE CARE	Pre-Certification required. Penalty listed above applies if not obtained. Includes coverage for bereavement counseling.		
-Inpatient		80% after deductible	50% after deductible
-Home		80% after deductible	50% after deductible
HOSPITAL FACILITY			
Inpatient Hospital	Pre-Certification required. Penalty listed above applies if not obtained.	80% after deductible	50% after deductible
Outpatient Hospital			
-Emergency Room for a medical Emergency		80%, after deductible	80%, after deductible
-Emergency Room for non-Emergency care		Not Covered	Not Covered
-Outpatient Surgical Center	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained.	80% after deductible	50% after deductible
INFUSION THERAPY	Pre-Certification required if performed anywhere except in physician's office. Penalty listed above applies if not obtained.	80%	50% after deductible
LABORATORY			
-Independent Facility		$50 Copay	50% after deductible
-Outpatient Hospital		$50 Copay	50% after deductible
-Physician's Office		PCP: 80%, Specialist: 80%	50% after deductible

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MASSAGE THERAPY (When rendered by a Licensed Massage Therapist)		Not covered	Not covered
MATERNITY CARE-MOTHER -Inpatient Hospital or Birthing Center -Physician for Prenatal Care and Delivery	Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. Penalty listed above applies if not obtained. Maternity Care for Dependents Not Covered.	80% after deductible 80% after deductible; routine prenatal care covered at 80%,	50% after deductible 50% after deductible
MENTAL ILLNESS SERVICES -Inpatient -Inpatient Physician -Outpatient -Office	Pre-Certification required on inpatient admissions. Penalty listed above applies if not obtained.	80% after deductible 80% after deductible $20 Copay per visit $20 Copay per visit	50% after deductible 50% after deductible 50% after deductible 50% after deductible
MODIFIED FOOD PRODUCT		Not Covered	Not Covered
NEWBORN CARE (Prior to Discharge) -Hospital -Physician	Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. Penalty listed above applies if not obtained.	80% after deductible 80% after deductible	50% after deductible 50% after deductible
NUTRITIONAL COUNSELING	Maximum of 6 visits per Benefit Year	80%	50% after deductible
OBESITY TREATMENT	Covered when Medically Necessary. Surgical Treatment is not covered.	Covered as described under type of service rendered	Covered as described under type of service rendered

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OCCUPATIONAL THERAPY	Maximum of 30 visits per Benefit Year		
-Office		80%, after deductible	50% after deductible
-Any Other Place of Service		80%, after deductible	50% after deductible
ORGAN TRANSPLANTS Guidelines apply – Refer to your Plan Document for more information on this benefit	Pre-Certification required. Penalty listed above applies if not obtained. Travel and Lodging up to $10,000 maximum per lifetime for patient, one companion or caregiver, both parents/guardians if a minor. Transplant provider must be more than 60 miles from patients home.	Covered as described under type of service rendered	Not Covered **for** Non-Approved/Non-Designated Facility
PHYSICAL THERAPY	Maximum of 30 visits per Benefit Year		
-Office		80%, after deductible	50% after deductible
-Any Other Place of Service		80%, after deductible	50% after deductible
PHYSICIAN			
-Inpatient		80%, after deductible	50% after deductible
-Office/Clinic (PCP)		80%, after deductible Copay per visit	50% after deductible
Consultation (Specialist)			
-Inpatient		80%, after deductible	50% after deductible
-Outpatient		80%, after deductible	50% after deductible
-Office/Clinic		80%, after deductible	50% after deductible
Second Medical Opinion		80%	50% after deductible
PREADMISSION TESTING		Refer to Laboratory and Diagnostic Tests benefits	Refer to Laboratory and Diagnostic Tests benefits
PREVENTATIVE/WELL CARE	Preventative/Well Care is covered as defined in the Patient Protection and Affordable Care Act, as amended.		
-Physician Office Services		100%	50% after deductible
-Lab, X-ray or other preventive tests		100%	50% after deductible
-Immunizations		100%	50% after deductible
-Women's Preventive Care	Covered as described by the Health Resources and Services Administration (HRSA)	100%	50% after deductible
-Mammograms (Routine) Includes coverage for routine 3D mammograms		100%	50% after deductible
-Routine Vision Exam		Not Covered	Not Covered
-Routine Hearing Screening		Not covered	Not covered

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PRIVATE DUTY NURSING	Covered under the Home Health Care Benefit	Not covered	Not covered
RADIATION THERAPY	Pre-Certification required. Penalty listed above applies if not obtained. Benefit includes treatment with radioactive substances as well as materials and services.		
-Outpatient Hospital		80%, after deductible	50% after deductible
-Office		80%, after deductible	50% after deductible
-Any Other Place of Service		80%, after deductible	50% after deductible
REHABILITATION FACILITY	Pre-Certification required. Penalty listed above applies if not obtained.	80% after deductible	50% after deductible
RESPIRATORY THERAPY			
-Outpatient Hospital		80%, after deductible	50% after deductible
-Any Other Place of Service		80%, after deductible	50% after deductible
SLEEP STUDIES AND TREATMENT	Pre-Certification required. Penalty listed above applies if not obtained. Must be Medically Necessary	80% after deductible	50% after deductible
SPEECH THERAPY	Maximum of 30 visits per Benefit Year		
-Office		80%, after deductible	50% after deductible
-Any Other Place of Service		80%, after deductible	50% after deductible
SKILLED NURSING FACILITY	Pre-Certification required. Penalty listed above applies if not obtained. Maximum of 60 days per Benefit Year.	80% after deductible	50% after deductible
SUBSTANCE ABUSE TREATMENT	Pre-Certification required on inpatient admissions. Penalty listed above applies if not obtained.		
-Detoxification		80% after deductible	50% after deductible
-Inpatient Rehabilitation		80% after deductible	50% after deductible
-Inpatient Physician		80% after deductible	50% after deductible
-Outpatient		80% after deductible	50% after deductible
-Office		80% Copay per visit	50% after deductible

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SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery) Surgeon -Inpatient -Outpatient -Office Assistant Surgeon Second Surgical Opinion	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained. Elective abortions are not covered.	 80% Copay after deductible 80% Copay after deductible 80% after deductible 80% after deductible 80% after deductible	 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible
SURGERY CENTER (Freestanding Surgical Facility)	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained.	80% after deductible	50% after deductible
TELEMEDICINE		80%	Not Covered
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)		Not covered	Not covered
TOBACCO CESSATION	Not covered except for services covered as described under Preventative/Well Care the Patient Protection and Affordable Care Act.	Not covered	Not covered
URGENT CARE FACILITY	Limited to 1 copay per day.	80%, after deductible Copay per visit	50% after deductible
WIGS	Covered when following cancer treatment. Limit of 1 per lifetime.	80%	80%

PRESCRIPTION DRUG EXPENSE BENEFIT

TYPE OF PROGRAM	IMPORTANT PROVISIONS	IN-NETWORK BENEFITS
PRESCRIPTION DEDUCTIBLE		None
PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM	Per Benefit Year	Combined with the Medical Out-of-Pocket Maximum
RETAIL	Up to 30-day supply	80% Copay, after deductible – Generic Drug 80% Copay, after deductible – Preferred Brand Name Drug 50% Coinsurance, after deductible – Non-Preferred Generic Drug
MAIL ORDER MAINTENANCE DRUGS	Up to a 80-day supply	80% Copay, after deductible – Generic Drug 80% Copay, after deductible – Preferred Brand Name Drug 50% Coinsurance, after deductible – Non-Preferred Generic Drug
SPECIALTY DRUGS		80% Copay after deductible
DIABETIC SUPPLIES AND INSULIN		See Benefits above
Prior authorization may be required for some drugs. **Drugs purchased at out-of-network pharmacies are not covered.** Certain preventive drugs, including oral contraceptives are covered in full, not subject to deductible. See www.healthcare.gov for more information. Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.