Refer to the Medical Plan Document and Summary Plan Description for details of Coverage.

MEDICAL BENEFITS	Employers Health Network PPO Providers www.members.EHNconnects.com	Non-PPO Providers
Member Calendar Year Deductible PPO & Non-PPO deductibles do not combine.	**Medical Plan Deducible** $1,000 per Individual / $2,000 per Family **Prescription Drug Deductible** $300 per Individual / $300 per Family	$10,000 per Individual $30,000 per Family
	The Calendar Year deductible does NOT include pre-certification penalties, non-covered expenses or charges in excess of Reasonable & Allowed charges. If enrolled for family coverage, each family member must meet their own individual deductible until the overall family deductible has been met.	
Plan Coinsurance	Plan pays 80% of covered expenses.	Plan pays 50% of Reasonable & Allowed Amount.
Member Out-of-Pocket Maximum PPO & Non-PPO Out-of-Pocket maximums do not combine.	$3,000 per Individual $6,000 per Family	$20,000 per Individual $40,000 per Family
	The Out-of-Pocket Maximum includes Medical & Prescription Drug Calendar Year deductibles, Member Coinsurance, Medical & Prescription Drug Co-payments. Pre-certification penalties, non-covered expenses and charges in excess of Reasonable & Customary charges do not accumulate towards the Out-of-Pocket Maximum. If enrolled for family coverage, each family member must meet their own individual Out-of-Pocket maximum until the overall family Out-of-Pocket maximum has been met.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment Pre-certification is required for Inpatient admissions and Partial Hospitalization / Intensive Outpatient Treatment.	▪ **Office Visit:** $20 Co-payment; not subject to Calendar Year deductible. ▪ **Hospital Clinic Visit:** 80% Coinsurance; subject to Calendar Year deductible. ▪ **Partial Hospitalization / Intensive Outpatient Treatment:** 100% of covered expenses; not subject to Calendar Year deductible. Includes Physician visits. ▪ **Inpatient Hospitalization**; 100% of covered expenses following a $750 per admission Hospital Co-payment; not subject to Calendar Year deductible. Includes Physician visits.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Allergy Injections & Testing Includes office visits & serum	$20 Co-payment per visit; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Ambulance Services	80% Coinsurance; subject to In-Network Calendar Year deductible. Limitations apply, refer to Plan for details.	
Autism Spectrum Disorders Treatment Pre-certification is required for ABA; limitations apply.	Benefits are based on services provided.	Benefits are based on services provided.
	Benefit limits do not apply to occupational, physical and speech therapies for treatment of autism spectrum disorders. includes habilitative and rehabilitative care, Applied Behavior Analysis (ABA), pharmacy care, psychiatric care, psychological care, therapeutic care and social work services.	
Birthing Center	100% of covered expenses following a $750 Co-payment; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Cardiac Rehabilitation Phase 1 & 2 only	$40 Co-payment; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Chemotherapy & Radiation Therapy Requires Pre-certification	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Chiropractic Services / Spinal Manipulation	$40 Co-payment; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Limited to 26 visits per Calendar Year.	
Clinical Trials	Benefits are based on services provided.	Benefits are based on services provided.
	Includes routine services during Approved Clinical Trials. Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services.	

MEDICAL BENEFITS	Employers Health Network PPO Providers www.members.EHNconnects.com	Non-PPO Providers
Dental / Oral Services Excludes excision of impacted wisdom teeth	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Diabetes Self-Management Training & Education	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Dialysis / Hemodialysis	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Durable Medical Equipment	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Pre-certification is required for insulin pumps and supplies, and equipment in excess of $2,500 and for Out-of-Network providers.	
Early Intervention Services Up to age 3	$20 Co-payment; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Emergency Room Services Includes Facility, Lab, X-ray & Physician services.	▪ **Emergency Care:** 100% of covered expense following a $250 Co-payment; subject to In-Network Calendar Year deductible. Co-payment will be waived if admitted on an inpatient basis to a Hospital. ▪ **Non-Emergency Care:** 80% Coinsurance; subject to In-Network Calendar Year deductible.	
Family Planning	▪ **For Women:** 100% of covered expenses; not subject to Calendar Year deductible. ▪ **For Men:** 80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Genetic Counseling, Testing & Related Services Pre-certification is required	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Note: Pre-certification is not required for BRCA Testing.	
Home Health Care Pre-certification is required	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Limited to 20 visits per Calendar Year.	
Hospice Care (Inpatient / Outpatient) Pre-certification is required	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Hospital Services (Inpatient) All Inpatient Hospital admissions require Pre-certification.	100% of covered expenses following a $750 per admission Hospital Co-payment; not subject to Calendar Year deductible. Includes surgical facility, supplies and miscellaneous Hospital charges.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Hospital Services (Outpatient) *Refer to Pre-certification requirements.	▪ **Clinic Services:** 80% Coinsurance; subject to Calendar Year deductible. ▪ **Outpatient Department:** 80% Coinsurance; subject to Calendar Year deductible. ▪ **Pre-admission Testing:** 80% Coinsurance; subject to Calendar Year deductible. ▪ **Outpatient Surgery in Hospital / Ambulatory Surgical Center:** 100% of covered expenses following a $500 Co-payment per procedure; not subject to Calendar Year deductible. *	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Injectables Pre-certification is required for injectables in excess of $1,500.	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Learning Deficiencies, Behavioral Problems & Developmental Delays	$20 Co-payment per visit; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Maternity Care Refer to Newborn Care for newborn benefits. Refer to Birthing Center for benefits, if applicable.	▪ **Physician delivery charges, prenatal/postpartum care, including planned home births:** 100% of covered expenses; not subject to Calendar Year deductible. ▪ **Inpatient Hospital charges:** $750 per admission Hospital Co-payment.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.

MEDICAL BENEFITS	Employers Health Network PPO Providers www.members.EHNconnects.com	Non-PPO Providers
Medical & Enteral Formula Requires Pre-certification. Includes metabolic formula.	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Mental Health Services Pre-certification is required for Inpatient admissions and Partial Hospitalization / Intensive Outpatient Treatment.	▪ **Office Visit:** $20 Co-payment; not subject to Calendar Year deductible. ▪ **Hospital Clinic Visit:** 80% Coinsurance; subject to Calendar Year deductible. ▪ **Partial Hospitalization / Intensive Outpatient Treatment:** 100% of covered expenses; not subject to Calendar Year deductible. Includes Physician visits. ▪ **Inpatient Hospitalization**; 100% of covered expenses following a $750 per admission Hospital Co-payment; not subject to Calendar Year deductible. Includes Physician visits.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Newborn Care Includes Physician visits & circumcision	100% of covered expenses; not subject to Calendar Year deductible. Admission Co-payment is waived for Newborn Care.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Orthotics	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Includes foot orthotics. Pre-certification is required for helmets and knee braces.	
Outpatient Imaging Includes MRI, CT & PET Scans Pre-certification is required	$500 Co-payment per scan. Please **Contact Karias Health** prior to imaging to determine if you are eligible for a $0 Co-payment.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Outpatient X-Ray & Laboratory Services Outpatient Hospital & Independent Facility	▪ **Diagnostic X-Rays**: $50 Co-payment per visit; not subject to Calendar Year deductible. ▪ **Laboratory:** 100% of covered expenses; not subject to Calendar Year deductible. ▪ **All other diagnostic tests:** $50 Co-payment per visit; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Outpatient Therapy Services Requires Pre-certification after 13 visits.	$40 Co-payment per visit; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Combined Outpatient Therapy maximum benefit of 25 visits for Physical Therapy, Speech Therapy and Occupational Therapy due to Illness or Injury.	
Physician Hospital Visits	100% of covered expenses; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Physician Office Visits Includes all related charges billed at time of visit. Pre-certification is required for on-going wound care.	▪ **Teladoc Virtual Visit:** $0 Co-payment. ▪ **Primary Care:** $20 Co-payment; not subject to Calendar Year deductible. ▪ **Specialist:** $40 Co-payment; not subject to Calendar Year deductible. ▪ **Urgent Care Facility / Walk-in Clinic:** $40 Co-payment; not subject to Calendar Year deductible. ▪ **Virtual Provider visits:** Paid based on services provided.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Podiatry Care	$40 Co-payment per visit; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.

<table>
<tr><th>MEDICAL BENEFITS</th><th>Employers Health Network PPO Providers
www.members.EHNconnects.com</th><th>Non-PPO Providers</th></tr>
<tr><td>Pre-certification Requirements
Failure to comply with the Pre-certification requirements of the Plan will result in a $750 reduction of benefits due to pre-certification non-compliance.</td><td colspan="2">Pre-admission certification is mandatory for all inpatient & outpatient facility-based services.
This includes all hospital admissions and all services at a hospital, surgical center, outpatient facility or dialysis center. Emergency hospital admissions must be approved within 48 hours.
Additional services requiring pre-certification are noted below.</td></tr>
<tr><td></td><td colspan="2">▪ All Inpatient Hospital Admissions
▪ All Outpatient Hospital Based Services
▪ Applied Behavior Analysis (ABA) Therapy
▪ Medical & Enteral Formula
▪ Chemotherapy & Radiation Therapy
▪ DME in excess of $2,500 and DME from Out-of-Network Providers
▪ Genetic Counseling, Testing & related Services
▪ Helmets & Knee Braces (orthotics)
▪ Home Health Care
▪ Inpatient Hospice Care
▪ Injectables in excess of $1,500
▪ Medical & Enteral Formula
▪ Outpatient Imaging
▪ Outpatient Therapy Services after 13 visits
▪ On going wound care</td></tr>
<tr><td>Prescription Drug Benefits

Tobacco cessation products are covered at 100%; Deductible waived.

Preventive Care drugs are not subject to the Prescription Drug Deductible.

Prescription purchased from Out-of-Network Pharmacies are not eligible for reimbursement by the Plan.

* See Covered Services section for coverage requirements related to specialty drugs.</td><td colspan="2">Prescription Drug Calendar Year Deductible: $300 per Individual / $300 per Family</td></tr>
<tr><td></td><td>Retail Pharmacy Program
(30-day supply maximum)
▪ Generic drugs: $10 Co-pay (deductible waived)
▪ Preferred Brand drugs: $60 Co-pay after Prescription Drug Calendar Year deductible.
▪ Non-Preferred Brand drugs: $100 Co-pay after Prescription Drug Calendar Year deductible.

Retail Maintenance Pharmacy Program
(90-day supply maximum)
▪ Generic drugs: $25 Co-pay (deductible waived)
▪ Preferred Brand drugs: $150 Co-pay after Prescription Drug Calendar Year deductible.
▪ Non-Preferred Brand drugs: $250 Co-pay after Prescription Drug Calendar Year deductible.</td><td>Mail Order Pharmacy
(90-day supply maximum)
▪ Generic drugs: $25 Co-pay (deductible waived)
▪ Preferred Brand drugs: $150 Co-pay after Prescription Drug Calendar Year deductible.
▪ Non-Preferred Brand drugs: $250 Co-pay after Prescription Drug Calendar Year deductible.

Specialty Drugs; Retail & Mail Order *
(30-day supply maximum)
▪ Generic drugs: $25 Co-pay (deductible waived)
▪ Preferred Brand drugs: $150 Co-pay after Prescription Drug Calendar Year deductible.
▪ Non-Preferred Brand drugs: $250 Co-pay after Prescription Drug Calendar Year deductible.</td></tr>
<tr><td>Prosthetic Appliances</td><td>80% Coinsurance;
subject to Calendar Year deductible.</td><td>50% of Reasonable & Allowed amount;
subject to Calendar Year deductible.</td></tr>
<tr><td></td><td colspan="2">Refer to Durable Medical Equipment benefit for Pre-certification requirements.</td></tr>
<tr><td>Respiratory Therapy</td><td>$40 Co-payment per visit;
not subject to Calendar Year deductible.</td><td>50% of Reasonable & Allowed amount;
subject to Calendar Year deductible.</td></tr>
<tr><td>Routine Colonoscopy
Age/frequency limitations apply</td><td>100% of covered expenses;
not subject to Calendar Year deductible.</td><td>50% of Reasonable & Allowed amount;
subject to Calendar Year deductible.</td></tr>
<tr><td>Routine Mammogram
Age/frequency limitations apply</td><td>100% of covered expenses;
not subject to Calendar Year deductible.</td><td>50% of Reasonable & Allowed amount;
subject to Calendar Year deductible.</td></tr>
<tr><td>Routine Well Adult Care

Age 18 and above</td><td>100% of covered expenses;
not subject to Calendar Year deductible.</td><td>50% of Reasonable & Allowed amount;
subject to Calendar Year deductible.</td></tr>
<tr><td></td><td colspan="2">This routine benefit includes, but is not limited to, physician charges for an annual routine examination, routine x-rays and laboratory, immunizations and the routine services listed below:
▪ Immunizations.
▪ Fasting lipoprotein profile (cholesterol screening).
▪ Annual Prostate Specific Antigen (PSA) screening.
▪ Tobacco use screening and cessation interventions.
▪ Fasting blood sugar screening (for diabetes mellitus).
▪ Blood pressure screening.
▪ Obesity screening and counseling.
▪ Annual colorectal screening.
▪ BRCA genetic counseling and testing.
▪ Statin preventive medication
▪ Bone Mineral Density (BMD) screening (once every 24 months).
▪ Women’s Health Services include pelvic exam & Pap test; screening for gestational diabetes; DNA Testing; HPV (Human Papillomavirus); counseling for sexually transmitted infections; counseling & screening for human immunodeficiency virus; screening & counseling for interpersonal and domestic violence; breastfeeding support & supplies; sterilization; and contraceptive methods & counseling. Limitations may apply.
A complete list of covered ACA mandated routine services for women / adults is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/</td></tr>
</table>

MEDICAL BENEFITS	Employers Health Network PPO Providers www.members.EHNconnects.com	Non-PPO Providers
Routine Well Child Care Birth through age 17	100% of covered expenses; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Includes Office Visit charges, immunizations, laboratory blood tests, developmental screening, behavioral assessments, routine vision screening & hearing screening for newborns. **A complete list of covered ACA mandated routine services for children is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/**	
Second Surgical Opinion	▪ **Primary Care:** $20 Co-payment; not subject to Calendar Year deductible. ▪ **Specialist:** $40 Co-payment; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Skilled Nursing Facility, Extended Care Facility & Rehabilitation Hospital Requires Pre-certification	$750 Co-payment per admission; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Combined Calendar Year maximum benefit of 60 days.	
Surgical Procedures Pre-certification is required for Outpatient surgery in a Hospital or Ambulatory Surgical Center.	▪ **Inpatient Hospital Surgery:** 100% of covered expenses following a $750 Hospital Co-payment; not subject to Calendar Year deductible. Surgeon fees are payable at 100%; not subject to Calendar Year deductible. ▪ **Outpatient Hospital / Ambulatory Surgical Center:** 100% of covered expenses following a $500 Co-payment per procedure; not subject to Calendar Year deductible. ▪ **PCP Office:** Included in $20 office visit Co-payment. ▪ **Specialist Office:** Included in $40 office visit Co-payment.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Temporomandibular Joint Disorders (TMJ) Treatment Requires Pre-certification	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
Transplant Benefits Requires Pre-certification	100% of covered expenses following a $750 per admission Hospital Co-payment; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
	Includes transportation, food and lodging expenses to a maximum benefit of $10,000 per transplant procedure.	
Urgent Care Facility & Walk-in Clinic	$40 Co-payment; not subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.
All Other Covered Medical Expenses	80% Coinsurance; subject to Calendar Year deductible.	50% of Reasonable & Allowed amount; subject to Calendar Year deductible.

Questions regarding Coverage and Benefits should be directed to:

Claims Administrator:

Preferred Benefit Administrators
PO Box 916188 Longwood, FL 32791-6188
407-786-2777 or 888-524-2777
www.PreferredTPA.com

Member Concierge Care:

Karias Health
888-832-0354
www.kariashealth.com

Locate Employers Health Network (EHN) Providers:

Members.EHNconnects.com