

Benefits Summary - Effective January 1, 2023

Benefit		
Hospital	In-Network Provider	Out-of-Network Provider
Calendar Year Deductible	BlueCard PPO/Beacon Health Options - \$500 / person; \$1,000 / family (combined w/ Medical)	Not covered
Inpatient (Room and Board and Ancillary Services)	90% of contract rate after \$100 copay	Not covered*
Outpatient Surgery	90% of contract rate after \$100 copay	Not covered
Emergency Room	90% of contract rate after \$100 copay; emergency room copay is waived if immediately confined	Not covered*
Coinsurance Out-of-Pocket Limit	\$2,750 / person; \$5,500 / family Combined Hospital and Medical (including MHSA)	None
Medical***	In-Network Provider	Out-of-Network Provider
Calendar Year Deductible	BlueCard PPO/Beacon Health Options - \$500 / person; \$1,000 / family (combined w/ Hospital)	\$500 / person; \$1,000 / family
Office Visit	No deductible; 100% of contract rate after \$25 copay (including telehealth)**	Medical: 60% of Plan's allowance MHSA: 70% of Plan's allowance
Surgeon	90% of contract rate	60% of Plan's allowance
X-ray and Lab	90% of contract rate	60% of Plan's allowance
Therapy (Occupational, Osteopathic, Physical, Speech, Vision)	90% of contract rate	60% of Plan's allowance
Maternity Care - Prenatal Visits	No deductible; 100% of contract rate	60% of Plan's allowance
Delivery	90% of contract rate	60% of Plan's allowance
Routine Physical Exam	No deductible; 100% of contract rate	60% of Plan's allowance
Routine Child Exam	No deductible; 100% of contract rate	60% of Plan's allowance
Routine Mammogram/Pap	No deductible; 100% of contract rate	60% of Plan's allowance
Hearing Aids	90% of contract rate up to a maximum payment of \$1,500 per device; one device per year per three-year period	60% of Plan's allowance up to a maximum payment of \$1,500 per device; one device per ear per three-year period
Coinsurance Out-of-Pocket Limit	\$2,750 / person; \$5,500 / family Combined Hospital and Medical (including MHSA)	None
Hospital / Medical / Rx Out-of-Pocket Maximum (includes Deductibles, Copays, Coinsurance)^^^	\$9,100 / person; \$18,200 / family	None

*Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-Network Level of Benefits.

***Mental Health and Substance Use Disorder (MHSA) Out-of-Network Provider services are covered at 70% of Plan's allowance.

**Telehealth includes medical and mental health office visits conducted virtually.

^^Certain specialty medications are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed will not be applied towards satisfying your out-of-pocket maximums by the manufacturer at no cost to you)

Benefits Summary (continued) - Effective January 1, 2023

Benefit	CVS Caremark Participating Retail Pharmacy	CVS Caremark Home Delivery (includes Specialty)
Prescription Drugs		
Calendar Year Deductible	\$75 / person; \$150 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill
Copay	The greater of:	
Generic	(Tier 1)- \$10 or 10%	(Tier 1) - \$20 or 10% ; max copay is \$50 / prescription
Preferred Brand	(Tier 2) - \$25 or 25%	(Tier 2) - \$50 or 25% ; max copay is \$125 / prescription
Non-Preferred Brand	(Tier 3) - \$40 or 40%	(Tier 3) - \$100 or 40%; max copay is \$300 / prescription
	In addition, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.	In addition to the maximum copays listed above, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication.
	Generic preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.	Generic preventive services medications, including contraceptives, are covered at 100% with no deductible or copay.
Specialty Medications^^	Generic - 30% Preferred Brand - 30% Non-Preferred Brand - 30% Note: Copay applies to all drugs in Specialty contract at all network pharmacies ****Additional savings on drugs may be available through Rx Savings Solutions	Generic - 30% Preferred Brand - 30% Non-Preferred Brand - 30% Note: Copay applies to all drugs in Specialty contract at all network pharmacies ****Additional savings on drugs may be available through Rx Savings Solutions
Mental Health and Substance Use Disorder	Beacon Health Options Provider	Out-of-Network Provider
Hospital and Alternative Levels of Care **	Covered under the Hospital Benefit	Not covered***
Medical	Covered under the Medical Benefit	Covered under the Medical Benefit
Dental	Delta Dental PPO Provider	Delta Premier and Out-of-Network Providers
Calendar Year Deductible	\$75 / person; \$200 / family	\$75 / person; \$200 / family
Diagnostic and Preventive Benefits	No deductible; 100%	75%
Basic Benefits	75%	75%
Major Benefits	50%	50%
Calendar Year Maximum^	\$2,500	\$2,500
Vision - Exam Plus Plan	Vision Service Plan Provider	Out-of-Network Provider
Eye Exams	100% after \$10 copay; one exam / calendar year	80% up to a maximum payment of \$50; one exam / calendar year
Glasses	20% discount	No benefit
Professional Services for Contact Lenses	15% discount	No benefit

^^Certain specialty medications are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed will not be applied towards satisfying your out-of-pocket maximums by the manufacturer at no cost to you)

**Alternative levels of care include Residential Treatment Center, Partial Hospital Program and Intensive Outpatient Program.

***Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-Network Level of Benefits.

****RX Savings Solutions is an online service through which you and your enrolled Dependents can find prescription medications at a lower cost. Register at myrxss.com.

^There is no dental maximum for individuals under age 19.