Medical Plan

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Your Medical Benefits

Your medical benefits offer coverage under the following Cigna Plans:

- Available to Pantex Guards Union (PGU):
    - Cigna Open Access Plus (OAP) Choice Fund with Health Savings Account (HSA) Plan
    - Cigna Open Access Plus (OAP) PGU Preferred Provider Option (PPO) Core Plan
    - Cigna Open Access Plus (OAP) PGU Preferred Provider Option (PPO) Select Plan

- Available to International Guards Union of America (IGUA) Y-12 Security Police Officers
    - Cigna Open Access Plus (OAP) Choice Fund with Health Savings Account (HSA) Plan
    - Cigna Open Access Plus (OAP) IGUA Preferred Provider Option (PPO) Core Plan
    - Cigna Open Access Plus (OAP) IGUA Preferred Provider Option (PPO) Select Plan

- Available to Atomic Trades and Labor Council (ATLC); International Guards Union of America (IGUA) Central Alarm Station Operators, Central Training Facility Instructors, and Beta 9 Operators; Metal Trades Council (MTC); Pantex and Y-12 Non-Bargaining; Y-12 Fire Captains and Lieutenants (FCLT); and United Steel Workers (USW)
    - Cigna Open Access Plus (OAP) Choice Fund with Health Savings Account (HSA) Plan
    - Cigna Open Access Plus (OAP) Preferred Provider Option (PPO) Core Plan
    - Cigna Open Access Plus (OAP) Preferred Provider Option (PPO) Select Plan

- If you temporarily reside outside of Tennessee or Texas, and Cigna has a local open access network available, you may be provided use of that network and receive in-network benefits.

- If you reside in an area where a Cigna network is not available:
    - Cigna Indemnity Plan

- Cigna has discretion to determine network availability.

- You may also choose to waive coverage. If you initially waive coverage, you may enroll during the next Open Enrollment period or when you experience a Qualifying Life Event, as described within the "About Your Benefits" section.

- Your Cigna plan will also provide protection and coverage for your Eligible Dependents under the same plan in which you are enrolled.

ⓘ **For more information about what happens to your medical benefits when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" section.**

Open Access Plus (OAP) Plans

How the Open Access Plus Plans Work

The PPO Core, PPO Select, and Choice Fund HSA center around a network of physicians, hospitals, and other health care providers who have agreed to provide care to patients at pre-negotiated rates.

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction, and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing Participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

When you select a participating provider, these Plans pay a greater share of the costs than if you select a non-participating provider. Participating providers are in-network Primary Care Physicians (PCPs) who are family or general practitioners, internists, and pediatricians who contract with Cigna to provide their services and charge only the contracted fee amount. Consult the Cigna website for a list of participating providers in your area. Participating providers are committed to providing you and your dependents appropriate care while lowering medical costs. A PCP is generally responsible for coordinating all health care. In-network PCPs and specialists also handle all inpatient and outpatient precertification.

For maximum coordination of your medical care, it is recommended that you choose a PCP. You are not required to choose a PCP or obtain a referral from a PCP in order to receive available benefits to you under these Plans. However, a PCP may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Eligible Dependents. For this reason, we encourage the use of PCPs and provide you with the opportunity to select a PCP from a list provided by Cigna for yourself and your Eligible Dependents. The PCP you choose for yourself may be different from the PCP you select for each of your Eligible Dependents.

You may select a new PCP by contacting Cigna at the member services number on your identification (ID) card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed. In addition, if at any time a PCP ceases to be a participating provider, you or your Eligible Dependents will be notified for the purpose of selecting a new PCP. For information on how to select a PCP, and for a list of the participating PCPs, visit www.myCigna.com or contact Cigna customer service at 1-855-247-0884.

Preventive care, like simple health screenings and immunizations, can help prevent or detect serious illnesses early, when they are less expensive to treat and you are more likely to fully recover. A PCP will provide a full range of preventive care based on recognized medical guidelines for your age, gender, and personal and family health histories. This care includes the following:

- immunizations
- annual well-woman/man exam
- well-child care
- cholesterol screenings
- prostate exams
- mammograms
- routine physical exams

With an OAP Plan, you have a choice each time you need health care to use only in-network providers, or to use providers outside the network and receive less benefits.

Under the OAP Plans:

- You do not need a referral to receive covered services from any participating specialist, but you may want your PCP's advice and assistance in arranging care with a specialist in the network. If you choose to see an out-of-network specialist, the health care services you receive will be covered at the out-of-network level.
- You do not need prior authorization from the Plan or from any other person (including a PCP) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or making referrals.
- For an Emergency, you will need to call your PCP within 48 hours after the Emergency to ensure in-network benefits and have your PCP coordinate any follow-up care.

Deductibles, Copayments, and Coinsurance

You and your Eligible Dependents may be required to pay a portion of the covered expenses for services and supplies. That portion is the Deductible, Copayment, or Coinsurance:

- Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount of the service. For example, if the medical plan's allowed amount for an overnight hospital stay is $1,000, your Coinsurance payment of 20% would be $200. This may change if you have not met your Deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- Copayments (Copay) are fixed dollar amounts you pay for covered health care, usually when you receive the service. Deductibles are expenses to be paid by you or your Eligible Dependents. Deductibles are in addition to any Coinsurance. Once the Deductible for your Plan has been reached, you and your family need not satisfy any further medical deductible for the remainder of that year.
- Copayments and Deductibles are expenses to be paid by you or your Eligible Dependents for services received.
- Deductible amounts are separate from, and not reduced by, Copayments.
- Copayments and Deductibles are in addition to any Coinsurance.
- The Plans encourage you to use in-network providers by charging you lower Deductibles, Copayments, and Coinsurance amounts.

For Deductibles, Copayments, or Coinsurance amounts, refer to the Summary of Benefits for your plan.

If You Have an Emergency

If you have an Emergency, go to the nearest emergency facility for treatment. You must contact your PCP or Cigna member services within 48 hours of your Emergency treatment to ensure in-network benefits are paid and to arrange for follow-up care.

If the situation is urgent, but not an Emergency, you should contact your PCP first and follow his or her directions or go to an in-network Urgent Care facility.

Definitions for "Emergency" and "Urgent Care" can be found in the Glossary.

If you need care while traveling outside your network area

You are covered for Emergency care or Urgent Care on an in-network basis, as long as you call your PCP or Cigna member services within 48 hours of receiving Emergency or Urgent Care. (If you are traveling outside the U.S., you may wait until you return home to contact your PCP. You must file a paper claim for reimbursement as soon as possible when you return).

The Network Credentialing Process

All network doctors (i.e., PCPs and specialists) must meet certain educational and professional requirements before they are admitted into the network. Cigna has a regular credentialing process to ensure the doctors in the network meet certain standards, such as the following:

- medical degree and current unrestricted state license
- admitting privileges at a network hospital
- board certification or board eligibility
- malpractice criteria
- good reputation among peers
- 24-hour emergency availability
- sufficient office hours to meet patient demand
- on-site review of office facilities

Cigna reviews its physicians regularly. If any physician does not meet the requirements, that physician will be dropped from the network.

Network hospitals are also credentialed. Hospitals are selected based on their facilities, services, medical outcomes, staff quality measures, and reputation in the community.

Cigna has the right to change network doctors and network hospitals at any time without advance notice.

Case Management

Coordinated by Cigna HealthCare, this is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Maximum Reimbursable Charge

Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply or on a percentage of a schedule based on a methodology similar to one used by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare-based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of one of the following:

- the provider's normal charge for a similar service or supply, or
- the charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the insurance company.

  Note 1: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Deductibles and Coinsurance.

  Note 2: Some providers forgive or waive the cost-share obligation (e.g., your Deductible and/or Coinsurance) that this Plan requires you to pay. Waiver of your required cost-share obligation can jeopardize your coverage under this Plan. For more details, see the Exclusions Section.

Out-of-Network Benefits

When you go out-of-network, you can use any physician or facility you like. After you meet an annual Deductible, the Plan pays the Maximum Reimbursable Charge for most kinds of medically necessary services until the annual Out-of-Pocket Maximum has been reached.

The Out-of-Pocket Maximum protects you by establishing a ceiling on the amount you pay for covered medical expenses during a year. Once you reach the Out-of-Pocket Maximum, the plan pays 100% of the Maximum Reimbursable Charge for the remainder of that year.

You must file paper claims to be reimbursed for out-of-network expenses. Claim forms are available from Cigna member services or Benefit Plans. If your physician recommends any non-emergency hospitalization or surgery, you are responsible for calling Cigna member services for hospital pre-certification at least seven days, or as soon as reasonably possible, before you are admitted to the hospital. If you do not call for pre-certification, your benefit will be reduced by 50%.

Pre-Certification Requirements

Pre-certification helps ensure all inpatient and certain outpatient services are medically necessary and, in the case of hospital confinement, the length of stay is appropriate.

If services are provided in-network, you do not have to worry about pre-certification. Your in-network PCP or specialist will handle it for you. But, if you go out-of-network for care, you are responsible for calling Cigna member services at least seven days, or as soon as possible, before you are admitted to the hospital or receive outpatient diagnostic testing or procedures. If you do not call, your benefit will be reduced.

When you call Cigna member services for pre-certification, you need to provide the following information:

- your name, address, and telephone number
- your physician's name and telephone number
- the date of your admission or services
- the reason for your admission or services

For the Indemnity plan, you are responsible for requesting certification. If you do not obtain approval through certification, penalties will apply.

Preadmission Certification (PAC)/ Continued Stay Review (CSR) for Hospital Confinement

Preadmission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of a hospital confinement when you or your Eligible Dependent requires treatment in a hospital:

- As a registered bed patient,
- For a partial hospitalization for the treatment of mental health or substance abuse, or
- For mental health or substance abuse residential treatment services.

PAC should be requested prior to any non-emergency treatment in a hospital described above. In the case of an emergency admission, the Review Organization should be contacted within 48 hours after the admission. For an admission due to pregnancy, the Review Organization should be contacted by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued hospital confinement.

Covered expenses incurred will be reduced for hospital charges made for each separate admission to the hospital unless PAC is received prior to the date of admission or, in the case of an emergency admission, within 48 hours after the date of admission.

Covered expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for bed and board, for treatment listed above for which PAC was performed, that are made for any day in excess of the number of days certified through PAC or CSR; or
- Any hospital charges for treatment listed above for which PAC was requested but that was not certified as medically necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted. In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the “Coordination of Benefits” section.

Outpatient Certification Requirements

Outpatient Certification refers to the process used to certify the medical necessity of outpatient diagnostic testing and outpatient procedures, including but not limited to, those listed in this section when performed as an outpatient in a free-standing surgical facility, other health care facility, or a physician’s office.

The toll-free number on the back of your ID card should be called to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures.

Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should be requested only for nonemergency procedures or services and should be requested at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered expenses incurred will be reduced for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed but that were not certified as medically necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Diagnostic tests and outpatient procedures that require certification include, but are not limited to, Advanced Radiological Imaging (e.g., CT scans, MRI, MRA, or PET scans) and hysterectomy.

Emergency Hospitalization

If you have a medical emergency and are admitted to the hospital, someone must call for pre-certification within two days of your admission or on the first business day following your admission, if later.

Filing Claims

If you stay in-network under the Open Access Plus (OAP) plans, your network provider is responsible for filing your claims.

To file a claim for out-of-network treatment under the Open Access Plus (OAP) plans or for any treatment under the Indemnity plan, you must complete a claim form and send it to Cigna within 90 days after the plan year in which services have been rendered.

Be sure to do the following:

- Include the account number listed on your ID card.
- Use a separate form for each covered dependent.
- Indicate whether you would like reimbursement of a payment you have made sent to you. Otherwise, it will be sent to the provider.

You can either attach itemized bills or have your physician complete the physician's section of the form. Either way, the following information must be provided:

- Patient's full name, date of birth, and relationship to you
- Physician's full name, address, and tax identification number
- Diagnosis code
- Date and charge for each service

Claim forms can be obtained from Cigna member services or Benefit Plans.

Coordination of Benefits

If you or any of your Eligible Dependents are covered under another medical plan, Cigna determines how benefits from all such plans will be coordinated.

Medical Insurance after Age 65 – During Active Service

If you continue working after age 65, you have the right to make one of the following elections:

- **Continue primary coverage under the Company medical plan**. In this case, the plan will pay benefits first. Your spouse and/or dependents can continue coverage under the company plan, as well. It is recommended; however, that you or any Medicare-eligible dependents enroll in Medicare Part A when eligible.
- **Cancel company health coverage and elect primary coverage under Medicare**. Should you elect this option, you should first compare benefits and costs of employer coverage and Medicare. If you are considering traditional Medicare, consider costs for Part B, a Part D prescription drug plan, and a Medigap supplemental insurance plan.
- With either election, please consult your Social Security office for additional guidance.

Company Right to Reimbursement (Subrogation)

If you or a covered dependent receives benefits for a covered expense and then collects payment for the same expense from a third party by settlement, judgment, or otherwise, you or your dependent must reimburse the Company for the amount of benefits paid by the plan or the amount received from the third party, whichever is less. This is called “subrogation.”

The plan is also granted a right of reimbursement of any recovery, whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and exclusive of the subrogation right granted under subrogation, but only to the extent of the benefits provided by the plan.

As a condition of participation in the medical plan, you and your covered Eligible Dependents agree to cooperate with the plan fully to permit the plan to recover the amounts it has paid or will pay on your or your covered Eligible Dependents’ behalf for an injury caused by a third party, but not more than these amounts. You or your covered Eligible Dependents may keep the portion of any recovery from or settlement with the third party or its insurer for your out-of-pocket medical expenses not covered by the plan, such as copayments and deductibles, and your reasonable attorney’s fees to obtain the recovery. The plan is entitled to recover these amounts regardless of whether the recovery is designated as compensation for medical expenses. It is your responsibility to notify the Plan Administrator when you or your covered dependent may have an injury that may entitle the plan to assert subrogation rights.

Mental Health/Alcohol and Substance Abuse Treatment

Under the Cigna OAP Plans, you must have mental health/alcohol and drug abuse treatment reviewed and authorized by calling the number listed on your ID card.

If you prefer, your PCP, local Employee Assistance Program, or your site's Occupational Health Services department can make the call for you. A PCP referral is not necessary.

Personal Health Team

Client-specific team of clinical specialists who provide support for healthy, at-risk, and acute-care individuals to help them stay healthy:

- Health and Wellness Coaching
- Cigna Well-Informed Program
- Preference Sensitive Care
- Behavioral Health Case Management
- 24-hour Health Information Line Outreach
- Pre-Admission Outreach
- Post-Discharge Outreach
- Inpatient Advocacy
- Case Management – Short-term and complex

Continuation of Medical Coverage (COBRA)

You and your covered Eligible Dependent may continue your medical coverage in certain cases when coverage would otherwise end. Refer to COBRA within the "Administrative Information" section.

Conversion Privileges

You may convert your coverage to an individual policy within 30 days after plan coverage terminates or during the final 180 days of continued contributory COBRA coverage—see the "Administrative Information" section—without taking a medical examination.

To convert your coverage, you must submit the appropriate form to the insurance company. Your cost for this coverage will be based on the insurance company's regular premium rates for the type of coverage you elect. Your coverage may differ from the coverage provided under this plan.

Conversion of plan coverage is also available to your Eligible Dependents if you die or if your Eligible Dependents no longer meet the plan's eligibility requirements. Your spouse may also convert coverage in the case of divorce or annulment.

Certificate of Creditable Coverage

Upon loss of coverage under these plans, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your Eligible Dependent may also request, without charge, a Certificate of Creditable Coverage at any time while enrolled in the plan and for 24 months following termination of coverage.

Cigna Member Services

Cigna member services is a customer service line staffed to answer your questions and provide information about your participation and benefits. Cigna member services can help you with the following:

- find out more about in-network PCP, specialists, and facilities
- get more information about plan features and procedures
- change PCP
- order replacement ID cards
- register comments about network providers and services
- request out-of-network claim forms

In Addition to Member Services:

You may locate participating providers in your Cigna network by accessing www.myCigna.com. Click on the "Provider Directory" link and follow the instructions for locating providers in your area.

As a Cigna member, you have access to your benefit information through your own personalized Cigna website. There you can do the following:

- locate participating providers
- change your PCP
- print a temporary ID card
- order a new ID card
- access your benefit information
- check the status of your claims

If you go out-of-network, you must also call Cigna member services for pre-certification.

ⓘ Contacting Cigna Member Services

Please call 1-855-247-0884 or log on to www.myCigna.com.

Information for All Medical Plans

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Open Access Plus (OAP) PGU Preferred Provider Organization (PPO) Core

Pantex Guards Union

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Summary of Benefits: Medical Plans

PGU PPO Core

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $250/Individual and $500/Family Out-of-network providers: $800/Individual and $1,600/Family Individual Deductible applies when the employee is the only person covered under the plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual and $6,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Calendar Year Deductible	$250/Individual $500/Family	$800/Individual $1,600/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Deductibles. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		

Summary of Benefits: Medical Plans

PGU PPO Core

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests		
• Routine services	Plan Pays 100%	Plan Pays 70% after deductible
• Non-routine services	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services		
PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
Specialist Office • All services including Lab and X-ray • Plan Pays 100% after your Copay	You Pay $30 Copay	Plan Pays 70% after deductible
Surgery Performed in the Physician's Office		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
Allergy Treatment/Injections		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility Services • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Core

Benefits	In-Network	Out-of-Network
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient		
Outpatient Facility Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation (includes coverage for developmental delays) **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $15 Copay	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis.	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Core

Benefits	In-Network	Out-of-Network
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 90% after deductible	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Aid • $5,000 maximum In-Network per pair per 36 months • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear; replacement batteries	Plan Pays 100%	Plan Pays 70% after deductible
Cochlear Implants	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Core

Benefit	In-Network	Out-of-Network
Lab and X-ray In: • Physician's Office • Specialist Office • Independent Lab • Outpatient Facility **Note**: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 90% Plan Pays 90%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Advanced Radiological Imaging In: • Physician's Office • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit. **Note 3**: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan	Plan Pays 70% after deductible Plan Pays 70% after deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Urgent Care** • Urgent Care Facility • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $125 Copay Per Visit Plan Pays 100% You Pay $30 Copay Plan Pays 100%	
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 90% after deductible	
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note**: Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Core

Benefit	In-Network	Out-of-Network
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants		
Inpatient Hospital Facility		
• Lifesource Facility	Plan Pays 100%	Not Covered
• Non-Lifesource Inpatient Facility	Plan Pays 90% after deductible	Not Covered
Inpatient Professional Services		
• Lifesource Facility	Plan Pays 100%	Not Covered
• Non-Lifesource Facility	Plan Pays 90% after deductible	Not Covered
Travel Lifetime Maximum to a Lifesource Facility $10,000 Per Transplant (If using an approved Lifesource facility)		
Maternity Initial Visit to Confirm Pregnancy		
• PCP Office Visit	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office Visit	You Pay $30 Copay	Plan Pays 70% after deductible
Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges)	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Office Visits in Addition to Global Maternity Fee		
Performed by Physician Office	You Pay $20 Copay	Plan Pays 70% after deductible
Performed by OB/GYN or Specialist	You Pay $30 Copay	Plan Pays 70% after deductible
Delivery Facility Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital benefit	Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Core

Benefit	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals)		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician		
• PCP Office	Plan Pays 100%	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Surgical and Non-Surgical Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-Surgical: Unlimited maximum per lifetime		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Core

Benefit	In-Network	Out-of-Network
Bariatric Surgery (in accordance with medical necessity requirements)		
• PCP Office	You pay $20 Copay	Not Covered
• Specialist Office	You pay $30 Copay	Not Covered
• Inpatient Facility	Plan Pays 90% after deductible	Not Covered
• Outpatient Facility	Plan Pays 90% after deductible	Not Covered
• Inpatient Professional Services	Plan Pays 90% after deductible	Not Covered
• Outpatient Professional Services	Plan Pays 90% after deductible	Not Covered
Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.		
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder		
Inpatient	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient - Physician's Office	You Pay $30 Copay	Plan Pays 70% after deductible
Outpatient - All Other Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Note 1: Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health - Outpatient		

Summary of Benefits: Medical Plans

PGU PPO Core

Benefit	In-Network	Out-of-Network
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services

PGU PPO Core

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Open Access Plus (OAP) PGU Preferred Provider Organization (PPO) Select

Pantex Guards Union

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Summary of Benefits: Medical Plans

PGU PPO Select

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $0/Individual and $0 family Out-of-network providers: $500/Individual and $1,000/Family	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual $6,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 100%	Plan Pays 70% after deductible
Calendar Year Deductible	None	$500/Individual $1,000/Family
• The amount you pay for all covered expenses counts toward your out-of-network Deductible. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		

Summary of Benefits: Medical Plans

PGU PPO Select

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests		
• Routine services	Plan Pays 100%	Plan Pays 70% after deductible
• Non-routine services	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services		
PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
Specialist Office	You Pay $25 Copay	Plan Pays 70% after deductible
Surgery Performed in the Physician's Office		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $25 Copay	Plan Pays 70% after deductible
Allergy Treatment/Injections		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $25 Copay	Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility: • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	You Pay $200 Copay Per Admission	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Select

Benefit	In-Network	Out-of-Network
Inpatient Hospital Physician's Visit/Consult	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after deductible
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit Copay	You Pay $100 Copay Per Facility/Visit	Plan Pays 70% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation • Includes coverage for developmental delay **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	You Pay $10 Copay	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $10 Copay	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 100%	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 100%	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 100%	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered

Summary of Benefits: Medical Plans

PGU PPO Select

Benefit	In-Network	Out-of-Network
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis.	Plan Pays 100%	Plan Pays 70% after deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 100%	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Aid • $5,000 maximum In-Network per pair per 36 months • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 100%	Plan Pays 70% after deductible
Cochlear Implants	Plan Pays 100%	Plan Pays 70% after deductible
Medical Specialty Drugs		
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Select

Benefit	In-Network	Out-of-Network
Lab and X-ray In: • PCP Office • Specialist Office • Independent Lab • Outpatient Facility **Note**: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Advanced Radiological Imaging In: • Physician's Office • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan	Plan Pays 70% after deductible You Pay $100 Copay Per Scan Plan Pays 70% after deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Urgent Care** • Urgent Care Facility • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $100 Copay Per Visit Plan Pays 100% You Pay $25 Copay Per Visit Plan Pays 100%	
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 100%	
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note**: Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Select

Benefit	In-Network	Out-of-Network
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants		
Inpatient Hospital Facility		
• Lifesource Facility	$200 Copay Per Visit	Not Covered
• Non-Lifesource Inpatient Facility	$200 Copay Per Visit	Not Covered
Inpatient Professional Services		
• Lifesource Facility	Plan Pays 100%	Not Covered
• Non-Lifesource Facility	Plan Pays 100%	Not Covered
Travel Lifetime Maximum to a Lifesource Facility $10,000 Per Transplant (If using an approved Lifesource facility)		
Maternity Initial Visit to Confirm Pregnancy:		
• PCP Office Visit	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office Visit	You Pay $25 Copay	Plan Pays 70% after deductible
Global Maternity Fee All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges	Plan Pays 100%	Plan Pays 70% after deductible
Office Visits in Addition to Global Maternity Fee		
PCP Office Visit	You Pay $20 Copay	Plan Pays 70% after deductible
Specialist Office Visit	You Pay $25 Copay	
Delivery Facility Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital benefit	Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $25 Copay	Plan Pays 70% after deductible
• Inpatient Facility	You Pay $200 Copay Per Visit	Plan Pays 70% after deductible
• Outpatient Facility	You Pay $100 Copay Per Visit	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PGU PPO Select

Benefit	In-Network	Out-of-Network
Family Planning – Men's Services		
Includes surgical services, such as vasectomy (Excludes reversals)		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $25 Copay	Plan Pays 70% after deductible
• Inpatient Facility	You Pay $200 Copay Per Visit	Plan Pays 70% after deductible
• Outpatient Facility	You Pay $100 Copay Per Visit	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Family Planning – Women's Services		
Includes surgical services, such as tubal ligation (Excludes reversals)		
Contraceptive devices as ordered or prescribed by a physician		
• PCP Office	Plan Pays 100%	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		

Summary of Benefits: Medical Plans

PGU PPO Select

Benefit	In-Network	Out-of-Network
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $25 Copay	Plan Pays 70% after deductible
• Inpatient Facility	You Pay $200 Copay Per Visit	Plan Pays 70% after deductible
• Outpatient Facility	You Pay $100 Copay Per Visit	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Bariatric Surgery (in accordance with medical necessity requirements)		
• PCP Office	You Pay $20 Copay Per Visit	Not Covered
• Specialist Office	You Pay $25 Copay Per Visit	Not Covered
• Inpatient Facility	You Pay $200 Copay Per Visit	Not Covered
• Outpatient Facility	You Pay $100 Copay Per Visit	Not Covered
• Inpatient Professional Services	Plan Pays 100%	Not Covered
• Outpatient Professional Services	Plan Pays 100%	Not Covered
Surgeon Charges Lifetime Maximum: $10,000		
Treatment of clinically severe obesity, as defined by the body mass index (BMI), is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.		
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		

Summary of Benefits: Medical Plans

PGU PPO Select

Benefit	In-Network	Out-of-Network
Mental Health or Substance Abuse Disorder		
• Inpatient	You Pay $200 Copay	Plan Pays 70% after deductible
• Outpatient - Physician's Office	You Pay $25 Copay	Plan Pays 70% after deductible
• Outpatient - All Other Services	Plan Pays 100%	Plan Pays 70% after deductible
Note 1: Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health - Outpatient		
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services

PGU PPO Select

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Open Access Plus (OAP) IGUA Preferred Provider Organization (PPO) Core

International Guards Union of America (IGUA) Y-12 Security Police Officers

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Summary of Benefits: Medical Plans

IGUA PPO Core

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $250/Individual and $500/Family Out-of-network providers: $800/Individual and $1,600/Family Individual Deductible applies when the employee is the only person covered under the plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual and $6,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Calendar Year Deductible	$250/Individual $500/Family	$800/Individual $1,600/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Deductibles. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		

Summary of Benefits: Medical Plans

IGUA PPO Core

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services • Non-routine services	Plan Pays 100% Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays 70% after deductible Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services		
PCP Office **Specialist Office** • All services including Lab and X-ray • Plan Pays 100% after your Copay	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility Services • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Core

Benefits	In-Network	Out-of-Network
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient		
Outpatient Facility Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation (includes coverage for developmental delays) **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $15 Copay	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis.	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Core

Benefits	In-Network	Out-of-Network
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 90% after deductible	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Aid • $5,000 maximum In-Network per pair per 36 months • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear; replacement batteries	Plan Pays 100%	Plan Pays 70% after deductible
Cochlear Implants	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Core

Benefit	In-Network	Out-of-Network
Lab and X-ray In: • Physician's Office • Specialist Office • Independent Lab • Outpatient Facility **Note**: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 90% Plan Pays 90%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Advanced Radiological Imaging In: • Physician's Office • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit. **Note 3**: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan	Plan Pays 70% after deductible Plan Pays 70% after deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Urgent Care** • Urgent Care Facility • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $125 Copay Per Visit Plan Pays 100% You Pay $30 Copay Plan Pays 100%	
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 90% after deductible	
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note**: Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Core

Benefit	In-Network	Out-of-Network
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants		
Inpatient Hospital Facility		
• Lifesource Facility	Plan Pays 100%	Not Covered
• Non-Lifesource Inpatient Facility	Plan Pays 90% after deductible	Not Covered
Inpatient Professional Services		
• Lifesource Facility	Plan Pays 100%	Not Covered
• Non-Lifesource Facility	Plan Pays 90% after deductible	Not Covered
Travel Lifetime Maximum to a Lifesource Facility $10,000 Per Transplant (If using an approved Lifesource facility)		
Maternity Initial Visit to Confirm Pregnancy		
• PCP Office Visit	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office Visit	You Pay $30 Copay	Plan Pays 70% after deductible
Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges)	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Office Visits in Addition to Global Maternity Fee		
Performed by Physician Office	You Pay $20 Copay	Plan Pays 70% after deductible
Performed by OB/GYN or Specialist	You Pay $30 Copay	Plan Pays 70% after deductible
Delivery Facility Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital benefit	Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Core

Benefit	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Surgical and Non-Surgical Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-Surgical: Unlimited maximum per lifetime • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Core

Benefit	In-Network	Out-of-Network
Bariatric Surgery (in accordance with medical necessity requirements)		
• PCP Office	You pay $20 Copay	Not Covered
• Specialist Office	You pay $30 Copay	Not Covered
• Inpatient Facility	Plan Pays 90% after deductible	Not Covered
• Outpatient Facility	Plan Pays 90% after deductible	Not Covered
• Inpatient Professional Services	Plan Pays 90% after deductible	Not Covered
• Outpatient Professional Services	Plan Pays 90% after deductible	Not Covered
Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.		
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder		
Inpatient	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient - Physician's Office	You Pay $30 Copay	Plan Pays 70% after deductible
Outpatient - All Other Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Note 1: Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health - Outpatient		

Summary of Benefits: Medical Plans

IGUA PPO Core

Benefit	In-Network	Out-of-Network
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services

IGUA PPO Core

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Open Access Plus (OAP) IGUA Preferred Provider Organization (PPO) Select

International Guards Union of America (IGUA) Y-12 Security Police Officers

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Summary of Benefits: Medical Plans

IGUA PPO Select

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $0/Individual and $0 family Out-of-network providers: $500/Individual and $1,000/Family	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual $6,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 100%	Plan Pays 70% after deductible
Calendar Year Deductible	None	$500/Individual $1,000/Family
• The amount you pay for all covered expenses counts toward your out-of-network Deductible. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		

Summary of Benefits: Medical Plans

IGUA PPO Select

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services • Non-routine services	Plan Pays 100% Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays 70% after deductible Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services		
PCP Office **Specialist Office**	You Pay $20 Copay You Pay $25 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	You Pay $20 Copay You Pay $25 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	You Pay $20 Copay You Pay $25 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility: • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	You Pay $200 Copay Per Admission	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Select

Benefit	In-Network	Out-of-Network
Inpatient Hospital Physician's Visit/Consult	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after deductible
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit Copay	You Pay $100 Copay Per Facility/Visit	Plan Pays 70% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation • Includes coverage for developmental delay **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	You Pay $10 Copay	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $10 Copay	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 100%	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 100%	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 100%	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered

Summary of Benefits: Medical Plans

IGUA PPO Select

Benefit	In-Network	Out-of-Network
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis.	Plan Pays 100%	Plan Pays 70% after deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 100%	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Aid • $5,000 maximum In-Network per pair per 36 months • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 100%	Plan Pays 70% after deductible
Cochlear Implants	Plan Pays 100%	Plan Pays 70% after deductible
Medical Specialty Drugs		
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Select

Benefit	In-Network	Out-of-Network
Lab and X-ray In: • PCP Office • Specialist Office • Independent Lab • Outpatient Facility **Note**: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Advanced Radiological Imaging In: • Physician's Office • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan	Plan Pays 70% after deductible You Pay $100 Copay Per Scan Plan Pays 70% after deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Urgent Care** • Urgent Care Facility • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $100 Copay Per Visit Plan Pays 100% You Pay $25 Copay Per Visit Plan Pays 100%	
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 100%	
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note**: Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Select

Benefit	In-Network	Out-of-Network
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants		
Inpatient Hospital Facility		
• Lifesource Facility	$200 Copay Per Visit	Not Covered
• Non-Lifesource Inpatient Facility	$200 Copay Per Visit	Not Covered
Inpatient Professional Services		
• Lifesource Facility	Plan Pays 100%	Not Covered
• Non-Lifesource Facility	Plan Pays 100%	Not Covered
Travel Lifetime Maximum to a Lifesource Facility $10,000 Per Transplant (If using an approved Lifesource facility)		
Maternity Initial Visit to Confirm Pregnancy:		
• PCP Office Visit	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office Visit	You Pay $25 Copay	Plan Pays 70% after deductible
Global Maternity Fee All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges	Plan Pays 100%	Plan Pays 70% after deductible
Office Visits in Addition to Global Maternity Fee		
PCP Office Visit	You Pay $20 Copay	Plan Pays 70% after deductible
Specialist Office Visit	You Pay $25 Copay	
Delivery Facility Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital benefit	Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $25 Copay	Plan Pays 70% after deductible
• Inpatient Facility	You Pay $200 Copay Per Visit	Plan Pays 70% after deductible
• Outpatient Facility	You Pay $100 Copay Per Visit	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

IGUA PPO Select

Benefit	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $25 Copay You Pay $200 Copay Per Visit You Pay $100 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		

Summary of Benefits: Medical Plans

IGUA PPO Select

Benefit	In-Network	Out-of-Network
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $25 Copay	Plan Pays 70% after deductible
• Inpatient Facility	You Pay $200 Copay Per Visit	Plan Pays 70% after deductible
• Outpatient Facility	You Pay $100 Copay Per Visit	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Bariatric Surgery (in accordance with medical necessity requirements)		
• PCP Office	You Pay $20 Copay Per Visit	Not Covered
• Specialist Office	You Pay $25 Copay Per Visit	Not Covered
• Inpatient Facility	You Pay $200 Copay Per Visit	Not Covered
• Outpatient Facility	You Pay $100 Copay Per Visit	Not Covered
• Inpatient Professional Services	Plan Pays 100%	Not Covered
• Outpatient Professional Services	Plan Pays 100%	Not Covered
Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI), is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.		
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		

Summary of Benefits: Medical Plans

IGUA PPO Select

Benefit	In-Network	Out-of-Network
Mental Health or Substance Abuse Disorder		
• Inpatient	You Pay $200 Copay	Plan Pays 70% after deductible
• Outpatient - Physician's Office	You Pay $25 Copay	Plan Pays 70% after deductible
• Outpatient - All Other Services	Plan Pays 100%	Plan Pays 70% after deductible
Note 1: Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health - Outpatient		
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services

IGUA PPO Select

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Open Access Plus (OAP) Choice Fund with Health Savings Account (HSA)

Atomic Trades and Labor Council (ATLC)

International Guards Union of America (IGUA) Central Alarm Station Operators, Central Training Facility Instructors, and Beta 9 Operators

Metal Trades Council (MTC)

Pantex & Y-12 Non-Bargaining

United Steel Workers (USW)

Y-12 Fire Captains and Lieutenants (FCLT)

Pantex Guards Union (PGU)

International Guards Union of America (IGUA) Y-12 Security Police Officers

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Summary of Benefits: Medical Plans

For Open Access Plus (OAP) Choice Fund with Health Savings Account (HSA)

The Choice Fund with HSA is a high deductible medical plan. This plan comes with an HSA which is a tax-advantaged bank account that allows you to save and then use tax-free dollars to pay for health care expenses in the months and years ahead.

Any money you and the Company contribute to your HSA will not be taxed. As long as you use your HSA funds to pay for eligible expenses, you will not be taxed. You can make tax-free contributions to your account up to the annual IRS limit. If you are age 55 or older, you can make additional contributions in accordance with IRS limits.

You will not be taxed on the amounts you use to pay for eligible expenses or the interest your account earns. Qualified expenses can include expenses not covered through your medical plans such as dental, vision, and prescription drugs. Eligible expenses are listed at www.cigna.com/expenses.

To use the money in your account you will receive a debit card that you can use at the doctor's office, pharmacy, and any other provider.

Your HSA balance is yours to use even if you no longer participate in a high deductible plan or leave the Company. The HSA funds are "portable". They stay with you if you change plans, retire, or terminate employment. When your HSA coverage ends you may still receive tax-free HSA distributions for eligible expenses (or withdraw funds on a taxable basis for ineligible expenses) but you may no longer make tax-free contributions to your HSA account.

Who is not eligible for the HSA:

- If you are currently not enrolled in a high deductible health plan
- You or an Eligible Dependent who is entitled to Medicare
- If you are claimed as a dependent under someone else's tax return

You may refer to IRS Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*, for additional information on HSA.

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual and $6,000/Family Deductible per person applies when the employee is the only person covered under the plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $4,000/Individual and $8,000/Family Out-of-network providers: $8,000/Individual and $16,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist?**	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Summary of Benefits: Medical Plans

Choice Fund HSA

<table>
<tr><th>Plan Highlights</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td colspan="3">Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.
Annual Employer Contribution:
For Individual Coverage: $250
For Family Coverage: $500</td></tr>
<tr><td>Maximum Lifetime Benefit</td><td>Unlimited</td><td>Unlimited</td></tr>
<tr><td>Coinsurance</td><td>Plan Pays 90%</td><td>Plan Pays 70%</td></tr>
<tr><td>Calendar Year Deductible</td><td>$1,500/Individual
$3,000/Family</td><td>$3,000/Individual
$6,000/Family</td></tr>
<tr><td colspan="3">• The amount you pay for in-network covered expenses only counts toward your in-network Deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network Deductibles.
• The Deductible must be met first before any Copay or Coinsurance will apply.
• This plan includes a combined medical/pharmacy plan Deductible.
• All eligible family members contribute towards the family plan Deductible. Once the family Deductible has been met, the plan will pay each eligible family member's expenses based on the Coinsurance level specified by the plan.
Note 1: If you cover only yourself in this plan, you need to meet the individual Deductible before the plan applies any Coinsurance or Copay for covered benefits.
Note 2: If you cover yourself and any dependents, the family Deductible will apply. You must meet the entire family Deductible before the plan applies any Coinsurance or Copay for covered benefits (there is no individual Deductible).</td></tr>
<tr><td>Calendar Year Out-of-Pocket Maximum</td><td>$4,000/Individual
$8,000/Family</td><td>$8,000/Individual
$16,000/Family</td></tr>
<tr><td colspan="3">• The amount you pay for in-network covered expenses only counts toward your in-network Out-of-Pocket Maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums.
• All Copays, Coinsurance, and Deductibles contribute toward your Out-of-Pocket Maximum.
• This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum.
• After each eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.</td></tr>
<tr><th colspan="3">Preventive Care</th></tr>
<tr><td>Preventive Care
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.</td><td>Plan Pays 100%</td><td>Not Covered</td></tr>
</table>

Summary of Benefits: Medical Plans

Choice Fund HSA

Plan Highlights	In-Network	Out-of-Network
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests		
• Routine services	Plan Pays 100%	Plan Pays 70% after deductible
• Non-routine services	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service

Benefits	In-Network	Out-of-Network
Physician Services		
PCP Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Specialist Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Surgery Performed in the Physician's Office		
• PCP Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Allergy Treatment/Injections		
• PCP Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

Choice Fund HSA

Benefits	In-Network	Out-of-Network
Outpatient		
Outpatient Facility Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Professional Services For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis	Plan Pays 90% after deductible	Plan Pays 70% after deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 90% after deductible	Not Covered

Summary of Benefits: Medical Plans

Choice Fund HSA

Benefits	In-Network	Out-of-Network
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 90% after deductible	Not Covered
Medical Specialty Drugs		
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Lab and X-ray **Note:** All lab and X-ray services, including Advanced Radiological Imaging (ARI), provided at Inpatient Hospital are covered under Inpatient Hospital benefit. Emergency Room/Urgent Care Facility are covered the same as Emergency Care/Urgent Care services.	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

Choice Fund HSA

Benefit	In-Network	Out-of-Network
Advanced Radiological Imaging In:		
• Physician's Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Emergency Room/Urgent Care Facility	Plan Pays 90% after deductible	Plan Pays 90% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Note 1: ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.		
Emergency Care		
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 90% after deductible
Urgent Care		
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 90% after deductible
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 90% after deductible	Plan Pays 90% after deductible
Hospice Care and Bereavement Counseling		
• Inpatient Hospital and Other Health Care Facilities	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Note: Services provided by mental health professionals are covered under mental health benefits.		
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants		
Inpatient Hospital Facility		
• Lifesource Facility	Plan Pays 100% after deductible	Not Covered
• Non-Lifesource Inpatient Facility	Plan Pays 90% after deductible	Not Covered
Inpatient Professional Services		
• Lifesource Facility	Plan Pays 100% after deductible	Not Covered
• Non-Lifesource Facility	Plan Pays 90% after deductible	Not Covered
Travel Lifetime Maximum to a Lifesource Facility $10,000 Per Transplant (If using an approved Lifesource facility)		

Summary of Benefits: Medical Plans

Choice Fund HSA

Benefit	In-Network	Out-of-Network
Maternity		
Initial Visit to Confirm Pregnancy	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Global Maternity Fee All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Delivery Facility Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital benefit	Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures		
• PCP Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals)		
• PCP Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

Choice Fund HSA

Benefit	In-Network	Out-of-Network
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician		
• PCP Office	Plan Pays 100%	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
• PCP Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Bariatric Surgery (in accordance with medical necessity requirements)		
• PCP Office	Plan Pays 90% after deductible	Not Covered
• Specialist Office	Plan Pays 90% after deductible	Not Covered
• Inpatient Facility	Plan Pays 90% after deductible	Not Covered
• Outpatient Facility	Plan Pays 90% after deductible	Not Covered
• Inpatient Professional Services	Plan Pays 90% after deductible	Not Covered
• Outpatient Professional Services	Plan Pays 90% after deductible	Not Covered
Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.		

Summary of Benefits: Medical Plans

Choice Fund HSA

Benefit	In-Network	Out-of-Network
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder Inpatient Outpatient - Physician's Office Outpatient - All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health - Outpatient	Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	Plan Pays 90% after deductible	Not Covered

Excluded Services

Choice Fund HSA

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Open Access Plus (OAP) Preferred Provider Organization (PPO) Core

Atomic Trades and Labor Council (ATLC)

International Guards Union of America (IGUA) Central Alarm Station Operators, Central Training Facility Instructors, and Beta 9 Operators

Metal Trades Council (MTC)

Pantex & Y-12 Non-Bargaining

United Steel Workers (USW)

Y-12 Fire Captains and Lieutenants (FCLT)

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Summary of Benefits: Medical Plans

PPO Core

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $400/Individual and $800/Family Out-of-network providers: $800/Individual and $1,600/Family Individual Deductible applies when the employee is the only person covered under the plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual and $6,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Calendar Year Deductible	$400/Individual $800/Family	$800/Individual $1,600/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Deductibles. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		

Summary of Benefits: Medical Plans

PPO Core

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services • Non-routine services	Plan Pays 100% Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays 70% after deductible Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services		
PCP Office **Specialist Office** • All services including Lab and X-ray • Plan Pays 100% after your Copay	You Pay $20 Copay You Pay $35 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	You Pay $20 Copay You Pay $35 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	You Pay $20 Copay You Pay $35 Copay	Plan Pays 70% after deductible Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility Services • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Core

Benefits	In-Network	Out-of-Network
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient		
Outpatient Facility Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation (includes coverage for developmental delays) **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	You Pay $25 Copay	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $25 Copay	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis.	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Core

Benefits	In-Network	Out-of-Network
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 90% after deductible	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear; replacement batteries	Plan Pays 90% after deductible	Not Covered
Cochlear Implants	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Core

Benefit	In-Network	Out-of-Network
Lab and X-ray In: • Physician's Office • Specialist Office • Independent Lab • Outpatient Facility **Note**: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 90% Plan Pays 90%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible
Advanced Radiological Imaging In: • Physician's Office • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit. **Note 3**: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Urgent Care** • Urgent Care Facility • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $150 Copay Per Visit Plan Pays 100% You Pay $35 Copay Plan Pays 100%	
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 90% after deductible	
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note**: Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 90% after deductible Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Core

Benefit	In-Network	Out-of-Network
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants		
Inpatient Hospital Facility		
• Lifesource Facility	Plan Pays 100%	Not Covered
• Non-Lifesource Inpatient Facility	Plan Pays 90% after deductible	Not Covered
Inpatient Professional Services		
• Lifesource Facility	Plan Pays 100%	Not Covered
• Non-Lifesource Facility	Plan Pays 90% after deductible	Not Covered
Travel Lifetime Maximum to a Lifesource Facility $10,000 Per Transplant (If using an approved Lifesource facility)		
Maternity Initial Visit to Confirm Pregnancy		
• PCP Office Visit	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office Visit	You Pay $35 Copay	Plan Pays 70% after deductible
Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges)	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Office Visits in Addition to Global Maternity Fee		
Performed by Physician Office	You Pay $20 Copay	Plan Pays 70% after deductible
Performed by OB/GYN or Specialist	You Pay $35 Copay	Plan Pays 70% after deductible
Delivery Facility Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital benefit	Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $35 Copay	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Core

Benefit	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals)		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $35 Copay	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician		
• PCP Office	Plan Pays 100%	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Surgical and Non-Surgical Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-Surgical: Unlimited maximum per lifetime		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $35 Copay	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 90% after deductible	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Core

Benefit	In-Network	Out-of-Network
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	You pay $20 Copay You pay $35 Copay Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible Plan Pays 90% after deductible	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder Inpatient Outpatient - Physician's Office Outpatient - All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health - Outpatient	Plan Pays 90% after deductible You Pay $35 Copay Plan Pays 90% after deductible	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Core

Benefit	In-Network	Out-of-Network
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services

PPO Core

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Open Access Plus (OAP)
Preferred Provider Organization (PPO)
Select

Atomic Trades and Labor Council (ATLC)

International Guards Union of America (IGUA) Central Alarm Station Operators, Central Training Facility Instructors, and Beta 9 Operators

Metal Trades Council (MTC)

Pantex & Y-12 Non-Bargaining

United Steel Workers (USW)

Y-12 Fire Captains and Lieutenants (FCLT)

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Summary of Benefits: Medical Plans

PPO Select

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-network providers: $0/Individual and $0 family Out-of-network providers: $500/Individual and $1,000/Family	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **out-of-pocket limits** on my expenses?	In-network providers: $1,500/Individual and $3,000/Family Out-of-network providers: $3,000/Individual $6,000/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 100%	Plan Pays 70% after deductible
Calendar Year Deductible	None	$500/Individual $1,000/Family
• The amount you pay for all covered expenses counts toward your out-of-network Deductible. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all covered expenses counts toward both your in-network and out-of-network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		

Summary of Benefits: Medical Plans

PPO Select

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services	Plan Pays 100%	Plan Pays 70% after deductible
• Non-routine services	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services		
PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
Surgery Performed in the Physician's Office • PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
Allergy Treatment/Injections • PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient		
Inpatient Hospital Facility: • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	You Pay $400 Copay Per Admission	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Select

Benefit	In-Network	Out-of-Network
Inpatient Hospital Physician's Visit/Consult	Plan Pays 100%	Plan Pays 70% after deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after deductible
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit Copay	You Pay $250 Copay Per Facility/Visit	Plan Pays 70% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation • Includes coverage for developmental delay **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	You Pay $20 Copay	Plan Pays 70% after deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $20 Copay	Plan Pays 70% after deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 100%	Plan Pays 70% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 100%	Plan Pays 70% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 100%	Plan Pays 70% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered

Summary of Benefits: Medical Plans

PPO Select

Benefit	In-Network	Out-of-Network
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis.	Plan Pays 100%	Plan Pays 70% after deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 100%	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 100%	Not Covered
Cochlear Implants	Plan Pays 100%	Plan Pays 70% after deductible
Medical Specialty Drugs		
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 100%	Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Select

Benefit	In-Network	Out-of-Network
Lab and X-ray In:		
• PCP Office	Plan Pays 100%	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 100%	Plan Pays 70% after deductible
• Independent Lab	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
Note: Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.		
Advanced Radiological Imaging In:		
• Physician's Office	You Pay$150 Copay Per Scan	Plan Pays 70% after deductible
• Emergency Room/Urgent Care Facility	You Pay $150 Copay Per Scan	You Pay $150 Copay Per Scan
• Outpatient Facility	You Pay $150 Copay Per Scan	Plan Pays 70% after deductible
Note 1: ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.		
Emergency Care		
• Emergency Room	You Pay $150 Copay Per Visit	
• Outpatient Professional Services	Plan Pays 100%	
Urgent Care		
• Urgent Care Facility	You Pay $30 Copay Per Visit	
• Outpatient Professional Services	Plan Pays 100%	
Note: Copays are waived if admitted.		
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 100%	
Hospice Care and Bereavement Counseling		
• Inpatient Hospital and Other Health Care Facilities	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Services	Plan Pays 100%	Plan Pays 70% after deductible
Note: Services provided by mental health professionals are covered under mental health benefits.		

Summary of Benefits: Medical Plans

PPO Select

Benefit	In-Network	Out-of-Network
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants **Inpatient Hospital Facility** • Lifesource Facility • Non-Lifesource Inpatient Facility **Inpatient Professional Services** • Lifesource Facility • Non-Lifesource Facility Travel Lifetime Maximum to a Lifesource Facility $10,000 Per Transplant (If using an approved Lifesource facility)	$400 Copay Per Visit $400 Copay Per Visit Plan Pays 100% Plan Pays 100%	Not Covered Not Covered Not Covered Not Covered
Maternity Initial Visit to Confirm Pregnancy: • PCP Office Visit • Specialist Office Visit **Global Maternity Fee** All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges **Office Visits in Addition to Global Maternity Fee** PCP Office Visit Specialist Office Visit **Delivery Facility** Inpatient Hospital, Birthing Center	You Pay $20 Copay You Pay $30 Copay Plan Pays 100% You Pay $20 Copay You Pay $30 Copay Covered same as Plan's Inpatient Hospital benefit	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay You Pay $400 Copay Per Visit You Pay $250 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible Plan Pays 70% after deductible

Summary of Benefits: Medical Plans

PPO Select

Benefit	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (Excludes reversals)		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
• Inpatient Facility	You Pay $400 Copay Per Visit	Plan Pays 70% after deductible
• Outpatient Facility	You Pay $250 Copay Per Visit	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (Excludes reversals) Contraceptive devices as ordered or prescribed by a physician		
• PCP Office	Plan Pays 100%	Plan Pays 70% after deductible
• Specialist Office	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Facility	Plan Pays 100%	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		

Summary of Benefits: Medical Plans

PPO Select

Benefit	In-Network	Out-of-Network
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after deductible
• Inpatient Facility	You Pay $400 Copay Per Visit	Plan Pays 70% after deductible
• Outpatient Facility	You Pay $250 Copay Per Visit	Plan Pays 70% after deductible
• Inpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
• Outpatient Professional Services	Plan Pays 100%	Plan Pays 70% after deductible
Bariatric Surgery (in accordance with medical necessity requirements)		
• PCP Office	You Pay $20 Copay Per Visit	Not Covered
• Specialist Office	You Pay $30 Copay Per Visit	Not Covered
• Inpatient Facility	You Pay $400 Copay Per Visit	Not Covered
• Outpatient Facility	You Pay $250 Copay Per Visit	Not Covered
• Inpatient Professional Services	Plan Pays 100%	Not Covered
• Outpatient Professional Services	Plan Pays 100%	Not Covered
Surgeon Charges Lifetime Maximum: $10,000		
Treatment of clinically severe obesity, as defined by the body mass index (BMI), is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.		
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		

Summary of Benefits: Medical Plans

PPO Select

Benefit	In-Network	Out-of-Network
Mental Health or Substance Abuse Disorder		
• Inpatient	You Pay $400 Copay	Plan Pays 70% after deductible
• Outpatient - Physician's Office	You Pay $30 Copay	Plan Pays 70% after deductible
• Outpatient - All Other Services	Plan Pays 100%	Plan Pays 70% after deductible
Note 1: Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health - Outpatient		
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services

PPO Select

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Dental Care (Children) • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S. • Private-Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program

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Indemnity

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Summary of Benefits: Medical Plans

Indemnity

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	$750/Individual and $1,500/Family Deductible per person applies when the employee is the only person covered under the plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there other **Deductibles** for specific services?	Yes. See Emergency Care and Urgent Care services.	You must pay this Deductible per visit.
Are there any **out-of-pocket limits** on my expenses?	$3,250/Individual and $6,500/Family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the **out-of-pocket limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	Out-of-Area
Maximum Lifetime Benefit	Unlimited
Coinsurance	Plan Pays 80% after deductible
Calendar Year Deductible	$750/Individual $1,500/Family
• Benefit Deductible always applies before plan Deductible and Coinsurance. • The amount you pay for all covered expenses counts toward your Deductible. • After an eligible family member meets his or her individual Deductible, covered expenses for that family member will be paid based on the Coinsurance level specified by the plan. After the family Deductible has been met, covered expenses for each eligible family member will be paid based on the Coinsurance level specified by the plan.	
Calendar Year Out-of-Pocket Maximum	$3,250/Individual $6,500/Family
• The amount you pay for all covered expenses counts toward your Out-of-Pocket Maximum. • All Coinsurance and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the plan will pay 100% of his or her covered expenses. After the family Out-of-Pocket Maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.	

Summary of Benefits: Medical Plans

Indemnity

Benefit	Out-of-Area
Preventive Care	
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%
Immunizations	Plan Pays 100%
Mammogram, PAP, and PSA Tests • Routine services	Plan Pays 100%
Physician Services	
PCP Office	Plan Pays 80% after deductible
Specialist Office	Plan Pays 80% after deductible
Surgery Performed in the Physician's Office	
• PCP Office	Plan Pays 80% after deductible
• Specialist Office	Plan Pays 80% after deductible
Allergy Treatment/Injections	
• PCP Office	Plan Pays 80% after deductible
• Specialist Office	Plan Pays 80% after deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 80% after deductible
Inpatient	
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 80% after deductible
Inpatient Hospital Physician's Visit/Consultation	Plan Pays 80% after deductible
Inpatient Professional Services: • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 80% after deductible

Summary of Benefits: Medical Plans

Indemnity

Benefit	Out-of-Area
Outpatient	
Outpatient Facility Services	Plan Pays 80% after deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 80% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 80% after deductible
Chiropractic Care • Calendar Year Maximum: 25 days	Plan Pays 80% after deductible
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private-duty nursing subject to medical necessity • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 80% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 80% after deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 80% after deductible
Breastfeeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis	Plan Pays 80% after deductible
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 80% after deductible

Summary of Benefits: Medical Plans

Indemnity

Benefit	Out-of-Area
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing-aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 80% after deductible
Cochlear Implants	Plan Pays 80% after deductible
Medical Specialty Drugs	
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 80% after deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 80% after deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 80% after deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 80% after deductible
Lab In:	
• Physician's Office	Plan Pays 80% after deductible
• Independent Lab	Plan Pays 80% after deductible
• Emergency Room/Urgent Care Facility	$150 Copay/$75 Copay after deductible
• Outpatient Facility	Plan Pays 80% after deductible

Summary of Benefits: Medical Plans

Indemnity

Benefit	Out-of-Area
Diagnostic and Advanced Radiological Imaging (ARI) In:	
• Physician's Office	Plan Pays 80% after deductible
• Independent Lab	Not Applicable
• Emergency Room/Urgent Care Facility	Plan Pays 100% after deductible
• Outpatient Facility	Plan Pays 80% after deductible
Note 1: ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	
Emergency Care	
• Emergency Room	You Pay $150 Copay Per Visit
• Outpatient Professional Services	Plan Pays 100% after deductible
Urgent Care	
• Urgent Care Services	You Pay $75 Copay Per Visit
• Outpatient Professional Services	Plan Pays 100% after deductible
Ambulance Services	
• If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.)	Plan Pays 80% after deductible
Note: Copays are waived if admitted.	
Hospice Care and Bereavement Counseling	
• Inpatient Hospital and Other Health Care Facilities	Plan Pays 80% after deductible
• Outpatient Services	Plan Pays 80% after deductible
Note: Services provided by mental health professionals are covered under mental health benefits.	
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants	
Inpatient Hospital Facility • Lifesource Facility	Plan Pays 80% after deductible
Inpatient Professional Services • Lifesource Facility	Plan Pays 80% after deductible
Travel Lifetime Maximum to a Lifesource Facility $10,000 Per Transplant (If using an approved Lifesource facility)	

Summary of Benefits: Medical Plans

Indemnity

Benefit	Out-of-Area
Maternity	
• Initial Visit to Confirm Pregnancy	Plan Pays 80% after deductible
Global Maternity Fee	
• All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges	Plan Pays 80% after deductible
Office Visits in Addition to Global Maternity Fee	Plan Pays 80% after deductible
Delivery Facility	
• Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures	
• Physician's Office	Plan Pays 80% after deductible
• Inpatient Facility	Plan Pays 80% after deductible
• Outpatient Facility	Plan Pays 80% after deductible
• Inpatient Professional Services	Plan Pays 80% after deductible
• Outpatient Professional Services	Plan Pays 80% after deductible
Family Planning – Men's Services	
Office Visits, Lab and Radiology Tests, and Counseling	Plan Pays 80% after deductible
Surgical Sterilization Procedures for Vasectomy (Excludes reversals)	
• Physician's Office	Plan Pays 80% after deductible
• Inpatient Facility	Plan Pays 80% after deductible
• Outpatient Facility	Plan Pays 80% after deductible
• Inpatient Professional Services	Plan Pays 80% after deductible
• Outpatient Professional Services	

Summary of Benefits: Medical Plans

Indemnity

Benefit	Out-of-Area
Family Planning – Women's Services • Physician's Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services **Note:** Includes coverage for contraceptive devices [i.e., Depo-Provera and Intrauterine Devices (IUDs)] as ordered or prescribed by a Physician. Diaphragms also are covered when services are provided in the Physician's office. Surgical Sterilization Procedures for Tubal Ligation (Excludes reversals)	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%
Infertility Services • Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-Surgical: Unlimited maximum per lifetime • Physician's Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI), is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible

Summary of Benefits: Medical Plans

Indemnity

Benefit	Out-of-Area
Mental Health and Substance Abuse Disorder Services	
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management • Inpatient Management Only • Inpatient utilization review and case management	
Mental Health or Substance Abuse Disorder • Inpatient • Outpatient - Physician's Office • Outpatient - All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	Plan Pays 80% after deductible Plan Pays 80% after deductible Plan Pays 80% after deductible

Excluded Services

Indemnity

Services Your Plan Does NOT Cover This is not a complete list. Check your policy or plan document for other **excluded services**.		
• Acupuncture • Cosmetic Surgery • Routine Eye Care (Children)	• Habilitation Services • Long-Term Care • Non-Emergency Care when Traveling outside the U.S.	• Private-Duty Nursing • Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Program