MEDICAL SCHEDULE OF BENEFITS - HEALTHY ADVANTAGE 2600 PLAN
Effective 1-1-2017

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Coinsurance rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out- of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible*** • Single Coverage • Family Coverage – Individual "Embedded" Deductible	 $2,600 $5,200 $2,600	 $4,000 $8,000 $4,000
Coinsurance Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	90%	70%
Annual Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** • Single Coverage • Family Coverage – Individual "Embedded" Out-Of-Pocket Maximum	 $3,600 $6,200 $3,600	 $5,000 $9,000 $5,000
Ambulance Transportation: • Paid By Plan After In-Network Deductible	90%	90%
Breast Pumps: • Paid By Plan	100% (Deductible Waived)	100% (After Deductible)
Contraceptive Methods And Counseling Approved By The FDA: • Paid By Plan	100% (Deductible Waived)	100% (After Deductible)
Durable Medical Equipment: • Paid By Plan After Deductible	90%	70%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care:		
• Paid By Plan After Deductible	90%	70%
Walk-In Retail Health Clinics:		
• Paid By Plan After Deductible	90%	70%
Emergency Room / Emergency Physicians:		
• Paid By Plan After Deductible	90%	90%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:		
• Maximum Days Per Occurrence For Same Or Related Condition	120 Days	
• Paid By Plan After Deductible	90%	70%
Home Health Care Benefits:		
• Maximum Visits Per Calendar Year	100 Visits	
• Paid By Plan After Deductible	90%	70%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits:		
• Paid By Plan After Deductible	90%	70%
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	90%	70%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	90%	70%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	90%	70%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	90%	70%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	90%	70%
Manipulations:		
• Paid By Plan After Deductible	90%	70%
Note: Medical Necessity Will Be Reviewed After 25 Visits.		

	IN-NETWORK	OUT-OF-NETWORK
Maternity:		
Routine Prenatal Services: (Applies Only To Services As Recommended By HHS)		
• Paid By Plan	100% (Deductible Waived)	70% (After Deductible)
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	90%	70%
One Postpartum Home Visit: ***(When The Mother And Newborn Child Are Voluntarily Discharged From A Hospital Earlier Than 48 Hours Following A Vaginal Delivery Or 96 Hours Following A Cesarean Section.)***		
• Paid By Plan After Deductible	100%	100%
Mental Health, Substance Use Disorder And Chemical Dependency Benefits:		
• Paid By Plan After Deductible	90%	70%
Morbid Obesity Treatment:		
• Maximum Benefit Per Lifetime	$10,000	
• Paid By Plan After Deductible	90%	70%
MRI, CT Scan, PET Scan, Nuclear Medicine, Ultrasound And Similar Imagining:		
• Paid By Plan After Deductible	90%	70%
Physician Office Visit:		
• Paid By Plan After Deductible	90%	70%
Physician Office Services:		
• Paid By Plan After Deductible	90%	70%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Immunizations:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Pelvic Exams And Pap Test:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine PSA Test And Prostate Exams:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Hearing Exams:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Eye Exam And Glaucoma Testing:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Eye Refractions:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Gestational Diabetes** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
***These Services May Also Apply To Men.**		

	IN-NETWORK	OUT-OF-NETWORK
Sterilizations: • Paid By Plan	100% (Deductible Waived)	70% (After Deductible)
Temporomandibular Joint Disorder Benefits: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	$1,500 90%	70%
Therapy Services: • Paid By Plan After Deductible ***Note: Medical Necessity Will Be Reviewed After 25 Visits.***	90%	70%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	2 Wigs, Toupees or Hairpieces Up to $500 90%	70%
All Other Covered Expenses: • Paid By Plan After Deductible	90%	70%

PRESCRIPTION SCHEDULE OF BENEFITS - HEALTHY ADVANTAGE PLAN OPTUM RX	
Annual Pharmacy Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Deductible.*** • Per Person • Per Family	 $2,600 $5,200
Annual Pharmacy Out-Of-Pocket Maximum Per Calendar Year: ***Note: Medical and Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum.*** • Per Person • Per Family • Individual "Embedded" Out-Of-Pocket Once The Annual Out-Of-Pocket Maximum Is Met, The Covered Person Pays Zero For Covered Prescription Medication.	 $3,600 $6,200 $3,600
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) Nonpreferred Brand-Name Drugs (Tier 3) • Maintenance Medications	For Up To A 30-Day Supply (After Deductible): $10 $30 $60 After 2 Retail Fills You Will Be Assessed A $10 Penalty Per Retail Fill Up To A 30-Day Supply In Addition To The Tier Copay (After Deductible)
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) Nonpreferred Brand-Name Drugs (Tier 3)	For Up To A 90-Day Supply (After Deductible): $20 $60 $120 After 2 Retail Fills, Mail Service Is Required Unless You Opt Out Each Year
Specialty Drugs • Covered Person's Co-pay Amount Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) Nonpreferred Brand-Name Drugs (Tier 3) ***Note: Specialty Drugs Must Be Purchased At A Specialty Pharmacy Vendor.***	For Up To A 30-Day Supply (After Deductible): 10% 10% 10%

By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To OptumRx For Reimbursement. Reimbursement For Covered Prescription Drugs Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.

Note: Deductible and/or co-pay may not apply to preventive prescription and over-the-counter products and contraceptives.

Note: The Covered Person must pay the Co-pay plus the difference in cost between a generic drug and a brand-name drug, regardless of circumstances.