

EDS

HDHP

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
GENERAL PROVISIONS Calendar Year Deductible (Applies to all Eligible Expenses) (Applies to out-of-pocket maximum) Deductible Credit from Prior Carrier Out-of-Pocket Maximum Lifetime Maximum per Participant	\$1,100 Employee Only or \$2,200 Family No \$5,600 Employee or Family per cal. yr. <i>Network deductible and out-of-pocket will also apply toward Network deductible and out-of-pocket</i>	\$3,300 Employee Only or \$6,600 Family No \$11,200 Employee or Family per cal. yr. <i>Out-of-Network deductible and out-of-pocket will also apply toward Network deductible and out-of-pocket</i>
INPATIENT HOSPITAL SERVICES (must be preauthorized) Penalty for Failure to Preauthorize	80% after cal. yr. deductible None	60% after cal. yr. deductible \$250
EMERGENCY ROOM/TREATMENT ROOM Accident & Medical Emergency Situation within 48 Hours Facility Charges Physician Charges Non-Emergency Situations Facility Charges Physician Charges	Unlimited 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible	70% after cal. yr. deductible 50% after cal. yr. deductible 50% after cal. yr. deductible
MEDICAL-SURGICAL SERVICES Services Performed in Physician Office (non-surgical), Including Lab & X-ray Immunizations (birth to the day of the 6 th birthdate) Physician Surgical Services in any Setting Lab & X-Ray in Other Outpatient Facilities (excluding Certain Diagnostic Procedures): <ul style="list-style-type: none"> • Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan Home Infusion Therapy (must be preauthorized) In-Vitro Fertilization Chiropractic Care – Office Services Speech and Hearing Services with Hearing Aids	70% after cal. yr. deductible Covered under Preventive Care 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible Lifetime Max of \$7,500 (covered as any other sickness) 70% after cal. yr. deductible 70% after cal yr deductible \$4,000 Maximum benefit per 36-month period for Hearing Aids	50% after cal. yr. deductible Covered under Preventive Care 50% after cal. yr. deductible 50% after cal. yr. deductible 50% after cal. yr. deductible 50% after cal. yr. deductible 50% after cal. yr. deductible 50% after cal yr deductible

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TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE Routine Physicals, Well Baby Care, Immunizations (after 6 th birthdate), Hearing Exams (routine vision is not covered)	100% 80% after cal yr. deductible	100% 80% after cal. yr. deductible
EXTENDED CARE SERVICES (must be preauthorized) Home Health Care Calendar Year Maximum Skilled Nursing Facility Hospice Care	80% after cal. yr. deductible 100 days / visits per cal. yr. 120 days / visits per cal. yr. 80% after cal yr deductible	60% after cal. yr. deductible 70% after cal yr deductible <i>Benefits used in Network or Out-of-Network apply towards satisfying both maximums.</i>
MENTAL HEALTH/CHEMICAL DEPENDENCY (must be preauthorized) Inpatient Services Hospital Services (Facility) Physician Services Calendar Year Limitations Outpatient Services Services Performed in Physician Office (non-surgical) Emergency Room/Treatment Room/Facility Charges (non-emergency only) Professional Provider Visits Allowed	80% after cal. yr. deductible 80% after cal. yr. deductible 45 inpatient days/45 physician visits 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible 45 outpatient visits per cal. yr.	60% after cal. yr. deductible 60% after cal. yr. deductible 25 inpatient days/25 physician visits <i>Days and visits used in Network or Out-of-Network apply towards satisfying both maximums.</i> 50% after cal. yr. deductible 50% after cal. yr. deductible 50% after cal. yr. deductible 25 outpatient visits per cal. yr.
SERIOUS MENTAL ILLNESS (must be preauthorized) Inpatient Services Hospital Services (Facility) Physician Services Calendar Year Limitations Outpatient Services Services Performed in Physician Office (non-surgical) Emergency Room/Treatment Room/Facility Charges (non-emergency only) Professional Provider Number of Outpatient Visits PRESCRIPTION DRUG BENEFIT	80% after cal. yr. deductible 90% after cal. yr. deductible 45 inpatient days/ 45 physician visits 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible 45 visits per cal. yr.	60% after cal. yr. deductible 70% after cal. yr. deductible 25 inpatient days/ 25 physician visits 50% after cal. yr. deductible 50% after cal. yr. deductible 50% after cal. yr. deductible 25 visits per cal. yr. Carved out but subject to the deductible and HRA reimbursement

EMPLOYEE INFORMATION

- This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.

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