

## Medical Schedule of Benefits –PPO Plan

	DISCOUNTED TIER Narrow Network (QCA)	PRIMARY TIER Regional Network (CHA)	National Network (Aetna)	Out-of-Network
<b>Search CDHP Network:</b>	See Listing on Page 3	<a href="http://www.chanetwork.com">www.chanetwork.com</a>	<a href="http://www.aetna.com">www.aetna.com</a>	Not Applicable
<b>Deductible</b>				
• Single	\$ 1,600	\$ 3,000	\$ 3,000	\$ 4,000
• Single + 1	\$ 2,400	\$ 4,500	\$ 4,500	\$ 6,000
• Family	\$ 3,200	\$ 6,000	\$ 6,000	\$ 8,000
<b>Co-Insurance Covered by Plan</b>	<b>95%</b>	<b>80%</b>	<b>80%</b>	<b>50%</b>
<b>Out-of-Pocket Maximum (Includes deductible, co-insurance and co-pays)</b>				
• Single	\$ 3,200	\$ 6,000	\$ 6,000	\$ 8,000
• Single + 1	\$ 4,800	\$ 9,000	\$ 9,000	\$ 12,000
• Family	\$ 6,400	\$ 12,000	\$ 12,000	\$ 16,000
<b>PRE-CERTIFICATION &amp; PRE-APPROVAL REQUIRED</b>	<b>See Pre-certification list for all procedures requiring pre-certification under this plan.</b>			
<b>COVERED SERVICES</b>				
<b>Inpatient &amp; Outpatient Hospitalization Surgery Centers</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>\$2,500 non-Beacon facility charge will be applied.</b>				
<b>Outpatient Diagnostic Imaging, Laboratory, X-rays</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>\$2,500 non-Beacon facility charge will be applied.</b>				
<b>Emergency Care</b>				
• Hospital				
• Med Point Urgent Care Facilities				
<b>\$2,500 non-Beacon facility charge will be applied for non-emergent use of Hospital Emergency Care.</b>				
	<b>Hospital: 95% after deductible Urgent Care: \$55/visit</b>	<b>Hospital: 80% after deductible Urgent Care: \$65/visit</b>	<b>Hospital: 80% after deductible Urgent Care: \$65/visit</b>	50% after deductible
<b>Physicians In-Patient Care</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Physician Surgical Services</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Physician and Mental Health Office Visits</b>	<b>Primary Care: \$25/visit Specialist: \$45/visit</b>	<b>Primary Care: \$35/visit Specialist: \$65/visit</b>	<b>Primary Care: \$35/visit Specialist: \$65/visit</b>	50% after deductible
<b>Physician Office Visits – Adult Wellness</b>	100% no deductible	100% no deductible	100% no deductible	No Coverage
<b>Prosthetics/Orthotics</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Mastectomy Bras</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
• Limit of 6 per lifetime				

<b>Organ Transplants</b> • Excludes experimental/investigational	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Pregnancy</b> • Excludes dependent pregnancy	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Routine Newborn Care</b> • Infant must be added within 31 days of birth • First four days of facility charges covered under Mother, if exceeds four days remainder covered under child	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Ambulance Service/Transport</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Diagnostic Laboratory</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Diagnostic X-Ray</b>	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Acupuncture</b> • 12 visits per calendar year	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Durable Medical Equipment</b> • Requires Pre-certification above \$1,000	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Home Health Care</b> • Subject to Pre-Certification/Utilization Review	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Hospice Care</b> • Subject to Pre-certification/Utilization Review	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Spinal Manipulation/Chiropractic</b> • 24 visits per calendar year • \$70 maximum allowable charge per visit (all services)	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Oral Maxillofacial Surgery</b> • Covered if medically necessary • Will coordinate with dental insurance	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Skilled Nursing Facility</b> • Limited to Semi-Private room rate- within 7 days of 5 day admittance; 100 days/calendar year limit	95% after deductible	80% after deductible	80% after deductible	50% after deductible
<b>Therapy</b> • Occupational, Physical or Speech	95% after deductible	80% after deductible	80% after deductible	50% after deductible

## PRESCRIPTION DRUG COVERAGE

<b>Pharmacy Benefit Manager</b>	A listing of preferred formulary drugs is available at <a href="http://Medtipster.com">Medtipster.com</a> and is subject to periodic updates.			
<b>Smoking Cessation Medication</b> (subject to plan limitations)	0% no deductible			Not Covered
<b>Specialty Medication</b> • Pre-certification and participation in Disease Management is required	<b>Beacon Pharmacy</b> 25% Co-pay \$750 Per Fill Max			Not Covered
<b>Compound Drugs</b>	20% co-pay after deductible, when purchased at Beacon Owned Pharmacy			Not Covered
<b>Prescription Drug Program</b> • Deductible waived for most maintenance medications, see HR intranet page for listing of these medications • Generic Drugs • Preferred Formulary Drugs • Non-Preferred Non-Formulary Drug • Minimum co-pay of \$5.00 per prescription	<b>Beacon Owned Pharmacy</b>  20% (\$10 minimum) 35% (\$10 minimum) 55% (\$10 minimum)	<b>Beacon Owned Pharmacy Disease Management Participants:</b>  10% (\$10 minimum) 25% (\$10 minimum) 45% (\$10 minimum)	<b>Other Network Pharmacy</b>  35% (\$10 minimum) 50% (\$10 minimum) 65% (\$10 minimum)	Not Covered

All Maintenance medications are required to be filled at a Beacon Pharmacy. Mail order option is available through Beacon Pharmacy; mailing cost may apply. Over-the-counter medications, with the exception of Prilosec OTC, Claritin OTC, Zyrtec OTC, and OTC Smoking Cessation medications are not covered by the plan.

**Beacon Owned/Joint Venture Provider/Facility Defined as:**

- Beacon Health, LLC
- Beacon Health Ventures
- Beacon Medical Group
- Beacon Granger Hospital
- Community Hospital of Bremen
- Elkhart General Hospital

- Franciscan Beacon Hospital
- Memorial Hospital of South Bend
- River Pointe Surgery Center
- Surgery Center of Granger
- South Bend Specialty Surgery Center

**Deductible and Out-of-Pocket Maximum**

- In-network amounts will accumulate in aggregate
- Out-of-Network will accumulate separately
- Facility Fee does not apply towards deductible or out-of-pocket maximum

**CHA Regional Network Defined as non-Beacon Provider-QCA/Facility in the following counties:**

- Adams County
- Alan County
- DeKalb County
- Elkhart County
- Huntington County
- Fulton County
- Kosciusko County
- Lake County
- LaPorte County

- LaGrange County
- Marshall County
- Noble County
- Porter County
- Pulaski County
- Wells County
- Whitley County
- Berrien County, MI
- Cass County, MI
- St. Joseph County, IN

**Facility Fee**

- Waiver available through appeal process for services not available in the Beacon Ownership Tier.

**For complete coverage listing, refer to the Summary Plan Description or contact Meritain Health prior to service.**

<b>PREVENTATIVE/WELLNESS SERVICES</b> <i>(Excludes Diagnostic Services)</i>		
<b>NOTE: There is no coverage for Preventative Services performed by out-of-network providers.</b>		
<b>Routine Service</b>	<b>Annual Frequency</b>	<b>In-Network Benefit</b>
<b>Exams &amp; Immunizations</b> <ul style="list-style-type: none"> <li>• Birth to Age 1</li> <li>• Age 1 to 2</li> <li>• Age 2 to 6</li> <li>• Age 6 to 18</li> <li>• Age 18 &amp; Over</li> </ul>	<ul style="list-style-type: none"> <li>• 6 Exams</li> <li>• 2 Exams per year</li> <li>• 1 Exam per year</li> <li>• 1 Exam per year</li> <li>• 1 Exam per year</li> </ul>	Covered 100% no deductible
<b>Gynecological PAP &amp; related domestic lab fees</b> <ul style="list-style-type: none"> <li>• Age 18 &amp; Over</li> </ul>	<ul style="list-style-type: none"> <li>• 1 Per year</li> </ul>	Covered 100% no deductible
<b>Mammography</b> <ul style="list-style-type: none"> <li>• Age 40 &amp; Over</li> </ul>	<ul style="list-style-type: none"> <li>• 1 Per year</li> </ul>	Covered 100% no deductible
<b>PSA</b> <ul style="list-style-type: none"> <li>• Age 40 &amp; Over</li> </ul>	<ul style="list-style-type: none"> <li>• 1 Per year</li> </ul>	Covered 100% no deductible
<b>Routine Lab (Virtual Wellness)</b> <ul style="list-style-type: none"> <li>• Associate and Spouse</li> </ul>	<ul style="list-style-type: none"> <li>• 1 Per year</li> </ul>	Covered 100% no deductible
<b>Colonoscopy</b>		

• Age 50 & Over	• 1 Every 10 years	Covered 100% no deductible
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PPO Plan 2024	
Full Time EE	Premium Per Pay
EE Only	57.01
EE + Spouse	136.82
EE+ Children	108.32
Family	188.13

CDHP Plan				
Full Time EE	2023 Premium Per Pay (11% of 2023 Total Cost)	Minimum per pay in 2024 if don't drop grievance (20% of 2023 Total Cost)	Minimum per pay in 2024 if we DO drop grievance (15% of 2023 Total Cost)	Beacon's 2024 contribution to HSA
EE Only	30.53	55.51	41.63	400
EE + Spouse	73.28	133.22	99.92	800
EE+ Children	58.01	105.46	79.1	800
Family	91.6	166.52	124.89	800