

MEDICAL SCHEDULE OF BENEFITS – HDHP A PLAN 2022-2023

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card Deductible) Single Family *NOTE: If you have Family coverage, the Family Deduction	\$1,500 \$3,000*	\$2,500 \$5,000*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	ctible must be satisfied before the	le i lan will pay any benefits.
(includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card) Single Family	\$5,500 \$11,000	N/A N/A
MEDICAL BENEFITS		
Allergy Serum & Injections	80% after Deductible	50% after Deductible
Ambulance Services		
Ground Ambulance Services	80% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance Services	Deductible, then \$200 Copay per trip, then 80%	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	80% after Deductible	50% after Deductible
Anesthesiologist	80% after Deductible	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	Deductible, then \$50 Copay per pair, then 80%	50% after Deductible
Calendar Year Maximum Benefit	3 pairs	
Cardiac Rehab (Outpatient)	80% after Deductible	50% after Deductible
Chemotherapy (Outpatient – includes all related charges)	80% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	20 visits	
Diabetic Supplies	80% after Deductible	50% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	80% after Deductible	50% after Deductible
Oncotype Diagnostic Testing	80% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	80% after Deductible	50% after Deductible



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	PROVIDERS	(Subject to Usual and Customary Charges)
Durable Medical Equipment (DME)	80% after Deductible	50% after Deductible
Emergency Services		
Emergency Medical Condition		
Facility Charges	80% after Deductible	Paid at Participating Provider level of benefits
Professional Fees and Ancillary Charges	80% after Deductible	Paid at Participating Provider level of benefits
Non-Emergency Medical Condition		
Facility Charges	80% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	80% after Deductible	50% after Deductible
Foot Orthotics	80% after Deductible	50% after Deductible
Maximum Benefit	Age 19 and over -	1 every 12 months;
	Under age 19 - 1 every 6 months	
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	80% after Deductible	50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
Hemodialysis (Outpatient)	80% after Deductible	50% after Deductible
Hinge Health Program (TIN 81-1884841)	100%; Deductible waived	N/A
NOTE : Please refer to the Hinge Health Program section If treatment is received from providers outside of the Hinge United in the Medical Schedule of Benefits.		
Home Health Care	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 v	isits
Hospice Care		
Inpatient	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	80% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.		
Infusion Therapy in Facility or Physician's Office	80% after Deductible	50% after Deductible



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	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and
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Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expe	enses for limitations.	
Medical and Surgical Supplies	80% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility Charge	Deductible, then \$250 Copay per admission, then 80%	50% after Deductible
Professional Fees	80% after Deductible	50% after Deductible
Outpatient Facility	80% after Deductible	50% after Deductible
Office Visits/Telemedicine	Deductible, then \$25 Copay	50% after Deductible
Participating Provider level of benefits will always apply Morbid Obesity (Surgical Treatment Only)		
Facility	Deductible, then \$250 Copay, then 80%	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Food Supplements	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits	
Pain Management	Paid based on place of service	Paid based on place of service
Calendar Year Maximum Benefit	N/A	4 visits
Physical Therapy (Outpatient)	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits	
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits/Telemedicine Primary Care Physician	Deductible, then \$25 Copay*	50% after Deductible 50% after Deductible
Specialist Physician Office Surgery	Deductible, then \$35 Copay* 80% after Deductible	50% after Deductible
Teladoc	100% after Deductible (\$49 consult fee applies toward the Deductible)	N/A
*Copay applies per visit regardless of what services are		



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	PROVIDERS
	(Subject to Usual and Customary Charges)
00%; Deductible waived	Not Covered
00% of the first \$300 per alendar Year, then 10% (Deductible waived)	Not Covered
00%; Deductible waived	100%; Deductible waived
80% after Deductible	50% after Deductible
1 ex	
paid under the Maternity B	Benefit. Please see Maternity
80% after Deductible	50% after Deductible
80% after Deductible	80% after Deductible
2 bras	
50% after Deductible	50% after Deductible
80% after Deductible	50% after Deductible
Deductible, then \$250 pay per admission, then 80%	50% after Deductible
60 days	
Deductible, then \$250 pay per admission, then 80%	50% after Deductible
60 days	
00%; Deductible waived	N/A
NOTE: SkinIO is technology-based skin cancer screenings – providing access for early detection of skin cancer via photo-taking; remote dermatologist review; mole mapping; and change tracking and outlier detection for earlier detection for persons age 18 and over. TIN: 85-3057521	
80% after Deductible	50% after Deductible
60 visits	
Deductible, then \$250 pay per admission, then 80%	50% after Deductible
0070	
	0% of the first \$300 per alendar Year, then 10% (Deductible waived) 0%; Deductible waived 80% after Deductible 1 ex paid under the Maternity B 80% after Deductible 2 br 50% after Deductible 2 br 50% after Deductible 90% after Deductible Deductible, then \$250 pay per admission, then 80% 60 d Deductible, then \$250 pay per admission, then 80% 60 d 0%; Deductible waived providing access for earlind change tracking and outer admission, then 80% 60 d 0%; Deductible waived providing access for earlind change tracking and outer admission, then 80% 60 d Deductible, then \$250 pay per admission, then 80% Consider Deductible 600 Deductible, then \$250 pay per admission, then



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Surgery (Outpatient)			
Facility	80% after Deductible	50% after Deductible	
Professional Services	80% after Deductible	50% after Deductible	
Temporomandibular Joint Dysfunction (TMJ)	Deductible, then \$50 Copay per occurrence, then 80%	50% after Deductible	
Lifetime Maximum Benefit:			
Surgical Procedure	1 Surgical	Procedure	
Appliances		liance	
Office Services	\$1,	000	
Transplants			
Facility Services	Deductible, then \$250 Copay per admission, then 80%	Not Covered	
	(Aetna IOE Program)*		
Professional Fees	80% after Deductible (Aetna IOE Program)*	Not Covered	
	Not Covered (All Other Network Providers)		
* Please refer to the Aetna Institute of Excellence (IO of this benefit, including travel and lodging maximum			
NOTE: Cornea transplants performed by any provide the same as any other Illness.	er are covered under the Plan as a	a separate benefit and paid	
Urgent Care Facility	Deductible, then \$45 Copay*	50% after Deductible	
*Copay applies per visit regardless of what services	are rendered.	1	
Wig (see Eligible Medical Expenses)	Deductible, then \$50 Copay per wig, then 80%	Deductible, then \$50 Copay per wig, then 80%	
Maximum Benefit	1 every 2	1 every 24 months	
All Other Eligible Medical Expenses	Deductible, then \$50 Copay per occurrence, then 80%	50% after Deductible	



PRESCRIPTION DRUG SCHEDULE OF BENEFITS - HDHP A PLAN 2022-2023

BENEFIT DESCRIPTION	BENEFIT	
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.		
CALENDAR YEAR DEDUCTIBLE (combined with major medical Deductible)		
Single	\$1,500	
Family	\$3,000*	
*NOTE: If you have Family coverage, the Family Deductible must be	be satisfied before the Plan will pay any benefits.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance – combined with major medical Out-of-Pocket)		
Single	\$5,500	
Family	\$11,000	
Retail Pharmacy: 30-day supply		
Generic Drug	\$15 Copay after Deductible	
Preferred Drug	80% after Deductible	
	\$25.00 Minimum \$80.00 Maximum	
Non-Preferred Drug	60% after Deductible	
	\$40.00 Minimum \$110.00 Maximum	
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)	
Mandatory Specialty Pharmacy Program: 30-day supply		
Specialty Drug	80% after Deductible	
	\$100.00 Minimum \$150.00 Maximum	
NOTE: Specialty Drugs MUST be obtained directly from the available at retail or mail order pharmacies and there are no g		
Retail/Mail Order: 90-day supply		
Generic Drug	\$30 Copay after Deductible	
Preferred Drug	80% after Deductible	
	\$50.00 Minimum \$175.00 Maximum	
Non-Preferred Drug	60% after Deductible	
	\$80.00 Minimum \$225.00 Maximum	
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)	

CVS True Accumulation Program

Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.



Mandatory Generic Program

The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

90-Day Supply - Maintenance Medications

This Plan will allow maintenance medications to be filled at any retail pharmacy and through mail order in 90 day quantities.

Mandatory Specialty Pharmacy Program

Self-administered specialty drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.