

St. James Hospital
General Information
Cost Sharing Expenses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|------------|----------------|---|
| Deductible - Single | \$3,000 | \$6,000 | |
| Deductible - Family | \$6,000 | \$12,000 | |
| Coinsurance | 20% | 40% | |
| Annual Out of Pocket Maximum - Single | \$6,000 | \$12,000 | Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services. |
| Annual Out of Pocket Maximum - Family | \$12,000 | \$24,000 | Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services. |
| Annual Out of Pocket Maximum - Per Person Cap | \$6,650 | \$24,000 | The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family. |

Office Visit Cost Shares

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---------------------------|--|--|-----------------------------------|
| Cost Share - Primary Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Cost Share - Specialist | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

Plan Limits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|------------|----------------|-----------------------------------|
| Plan/Calendar Year | | | Plan Year Benefits |
| Diabetic Preauthorization and Step Therapy | | | Applies |
| Medical Preventive Services Prior to Deductible | | | No |

Who is Covered

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---------------------------|------------|----------------|-----------------------------------|
| Domestic Partner Coverage | | | Covered |

Inpatient Services

Inpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|------------------------------|--|--|---|
| Inpatient Hospital Services | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Mental Health Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Substance Use Detoxification | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Skilled Nursing Facility | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 45 Days per plan year Limits are combined INN and OON. |
| Physical Rehabilitation | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 60 Days per plan year Limits are combined INN and OON. |
| Maternity Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|----------------------------|--|--|--|
| Inpatient Hospital Surgery | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Anesthesia | PCP/Specialist - 20% Coinsurance Subject to Deductible | 20% Coinsurance Subject to \$3,000 Deductible | Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral. |

Outpatient Facility Services

Outpatient Facility Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|--|--|--|--|
| SurgiCenters and Freestanding Ambulatory Centers Surgical Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Diagnostic X-ray | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Diagnostic Laboratory and Pathology | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Radiation Therapy | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Chemotherapy | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Infusion Therapy | Inclusive of Primary Service | Inclusive of Primary Service | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Mental Health Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | Includes Partial Hospitalization |

Home and Hospice Care

Home Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-----------------------|--|--|--|
| Home Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care). |
| Home Infusion Therapy | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

Hospice Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|------------------------|--|--|-----------------------------------|
| Hospice Care Inpatient | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

Outpatient and Office Professional Services

Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------------|--|--|--|
| Office Surgery | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Chemotherapy | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Infusion Therapy | PCP/Specialist - Inclusive of Primary Service | Inclusive of Primary Service | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Mental Health Care | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Maternity Care | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Telehealth | PCP/Specialist - 0% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| TeleMedicine Program | PCP/Specialist - 0% Coinsurance Subject to Deductible | Not Covered | Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions. |
| Chiropractic Care | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-----------------------------------|---|--|--|
| Allergy Testing | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 1 Exam per plan year Limits are combined INN and OON. |

Rehab and Habilitation

Outpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-----------------------------|--|--|--|
| Physical Rehabilitation | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |

Outpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-----------------------------|---|--|--|
| Physical Rehabilitation | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------------|----------------------------------|--|-----------------------------------|
| Adult Physical Examination | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | 1 Exam per plan year |
| Adult Immunizations | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Well Child Visits and Immunizations | PCP/Specialist - Covered in Full | 0% Coinsurance | |
| Routine GYN Visit | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------------|----------------------------------|--|-----------------------------------|
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |

Preventive Facility Services Meeting Federal Guidelines*

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---------------------------------|-----------------|--|-----------------------------------|
| Cervical Cytology Preventative | Covered in Full | 40% Coinsurance Subject to Deductible | |
| Mammography Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | |

Preventive services in addition to those required under Federal Guidelines - Professional

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------------|--|--|-----------------------------------|
| Prostate Cancer Screening | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

Preventive services in addition to those required under Federal Guidelines - Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---------------------------------|--|--|-----------------------------------|
| Mammography Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

Other Benefits

Additional Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|--|--|--|--|
| Treatment of Diabetes Insulin and Supplies | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. |
| Diabetic Equipment | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|----------------------|---|--|-----------------------------------|
| Medical Supplies | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Acupuncture | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Private Duty Nursing | PCP/Specialist - Not Covered | Not Covered | Not Covered |

Emergency Services

ER Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------|--|--|--|
| Facility Emergency Room Visit | 20% Coinsurance Subject to Deductible | 20% Coinsurance Subject to \$3,000 Deductible | Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. |

Transportation

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|--|--|--|-----------------------------------|
| Prehospital Emergency and Transportation - Ground or Water | 20% Coinsurance Subject to Deductible | 20% Coinsurance Subject to \$3,000 Deductible | |

Urgent Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-----------------------------------|--|--|-----------------------------------|
| Urgent Care Center Facility Visit | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

Ancillary Benefits

Vision

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------|-------------|----------------|-----------------------------------|
| Pediatric Eye Exams - Routine | Not Covered | Not Covered | Not Covered |
| Pediatric Eyewear - Routine | Not Covered | Not Covered | Not Covered |
| Adult Eye Exams - Routine | Not Covered | Not Covered | Not Covered |
| Adult Eyewear - Routine | Not Covered | Not Covered | Not Covered |

Rx Benefits

Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|--------------|------------|----------------|-----------------------------------|
| Rx Plan | | | \$5/\$35/\$70 Integrated Rx |

Rx Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|------------------------------|-------------------|-----------------------|--|
| Days Supply Per Retail Order | 30 | | |
| Days Supply Per Mail Order | 90 | | |
| Copays Per Mail Order Supply | 2 | | |

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.