2020 MEDICAL BENEFITS SCHEDULE

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Lifetime Maximum	Unlimited		
Calendar Year Deductible			
• Individual	$500	$1,000	$2,000
• Family	$1,000	$2,000	$4,000
Covered expenses for Open Access III Providers and PPO Providers will accumulate to satisfy the Open Access III Providers and PPO Providers deductible amounts simultaneously until the Open Access III Providers and PPO Providers deductible amounts are satisfied. However, only charges made by Non-Network providers will be used to satisfy the Non-Network deductible amounts.			
Calendar Year Out-of-Pocket Maximum (including deductible, coinsurance and medical and prescription drug copays)			
• Individual	$2,500	$3,000	$5,000
• Family	$5,000	$6,000	$7,500
Covered expenses for Open Access III Providers, PPO Providers or Non-Network providers will accumulate to satisfy the Open Access III Providers, PPO Providers or Non-Network Providers out-of-pocket maximums simultaneously until the Open Access III Providers and PPO Providers out-of-pocket maximums are satisfied. However, only charges made by Non-Network providers will be used to satisfy the remainder of the Non-Network out-of-pocket maximum.			
Health Reimbursement Account Services rendered at an Open Access III Provider that are more than 50 miles from Hannibal, MO are eligible for a reimbursement of $250 per occurrence with a maximum of $500 per person/$1,000 per family.			
Utilization Review Requirements Please refer to the HealthLink pre-certification list for full details. It is the Employee's responsibility to obtain pre-certification or benefits will be reduced by a $500 penalty. Penalty does not apply toward the Calendar Year deductible or out-of-pocket maximum.			
Hospital Services • Inpatient **(See Utilization Review Requirements)**	100% after deductible	80% after deductible	50% after deductible
• Outpatient	100% after deductible	80% after deductible	50% after deductible
• Inpatient Services and Outpatient Surgery performed at any facility owned or operated by **Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic Hannibal and Quincy, Blessing Physician Services, Quincy Medical Group, and Northeast MO Ambulatory Surgery Center**. **DOES NOT APPLY TO EMERGENCY SERVICES, MATERNITY SERVICES OR PHYSICIAN OFFICE VISITS.**	$500 copay per occurrence, then 100% after deductible	80% after deductible	50% after deductible
Diagnostic Services (Lab and X-Ray performed in the physician office)	100% after deductible		
Diagnostic Services (MRI, PET or CT Scans)	100% after deductible	80% after deductible	50% after deductible
MRI, PET or CT Scans performed at Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic, Blessing Physician Services, and Quincy	$500 Copay then 100% after deductible		
Emergency Room Services	100% after deductible	100% after deductible	100% after deductible

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDER
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Hospital Pre-Admission Testing Within 7 days prior to admission.	100% after deductible	80% after deductible	50% after deductible
Second Surgical Opinion Voluntary	100% no deductible	100% no deductible	100% no deductible
Physician Office Visits	100% after deductible	80% after deductible	50% after deductible
Other Physician Services • Hospital visits • Surgeon and assistant surgeon • Anesthesiologist • Radiologist and pathologist • Emergency room Physician	100% after deductible	80% after deductible	50% after deductible
Note: Services of radiologists, anesthesiologists, pathologists and emergency room Physicians will be reimbursed at the same benefit level as the facility where the services are performed.			
Outpatient X-ray and Laboratory Services	100% after deductible	80% after deductible	50% after deductible
Maternity Female Employee and Spouse.	100% after deductible	80% after deductible	50% after deductible
Well Newborns Well newborn expenses for Hospital, Physician visits and circumcision while mother and baby are confined are paid as part of mother's claim.	100% after deductible	80% after deductible	50% after deductible
Wellness Care			
• Well Child Care, including office visits, routine examinations and laboratory tests as recommended by the American Academy of Pediatrics for up to age 6.	100% no deductible	100% no deductible	50% after deductible
• Immunizations:			
- Birth through 18	100% no deductible	100% no deductible	50% after deductible
• Routine Care – ages 6 and above as follows: - Mammogram – one per Calendar Year unless recommended more frequently by a Physician - Pap smear, including exam – one per Calendar Year - Prostate screening, including exam and any required tests - one per Calendar Year - Colorectal cancer screening and related tests - one per Calendar Year - Flu shot – one per Calendar Year - Screening colonoscopies in accordance with AMA guidelines.	100% no deductible	100% no deductible	50% after deductible

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Mental/Nervous Disorders			
- Inpatient treatment - Hospital **(See Utilization Review Requirements)** - Partial Hospitalization – two partial days equals one Inpatient day. - Residential treatment facility - Physician	100% after deductible	80% after deductible	50% after deductible
- Inpatient Services at **Hannibal Regional and Blessing Hospital**	$500 copay per occurrence, then 100% after deductible	N/A	N/A
• Outpatient treatment - Psychotherapy. - Medicine checks, Diagnostic Charges, etc.	100% after deductible	80% after deductible	50% after deductible
Alcoholism and Drug Abuse			
• Inpatient treatment - Hospital **(See Utilization Review Requirements)** - Partial Hospitalization – two partial days equals one Inpatient day. - Residential treatment facility - Physician	100% after deductible	80% after deductible	50% after deductible
- **Inpatient Services at Hannibal Regional and Blessing Hospital**	$500 copay per occurrence, then 100% after deductible	N/A	N/A
- Outpatient treatment	100% after deductible	80% after deductible	50% after deductible
Skilled Nursing Facility Must be within 14 days of a 3-day Hospital or Skilled Nursing Facility confinement, up to a maximum of 70 days per Calendar Year.	100% after deductible	80% after deductible	50% after deductible
Home Health Care Limited to a maximum of 100 visits per Calendar Year. One visit equals 4 hours.	100% after deductible	80% after deductible	50% after deductible
Hospice Care Limited a Lifetime maximum of 70 days, Inpatient or Outpatient.	100% after deductible	80% after deductible	50% after deductible
Physical, Speech & Occupational Therapy Limited to a combined maximum of 90 visits per Calendar Year	100% after deductible	80% after deductible	50% after deductible
Ambulance	100% after deductible		
Durable Medical Equipment	100% after deductible	80% after deductible	50% after deductible
Chiropractic Care Limited to a maximum of 26 visits per Calendar Year, including Diagnostic Charges.	100% after deductible	80% after deductible	50% after deductible
Temporomandibular Joint (TMJ) Syndrome Limited to a maximum of $5,000 per Calendar Year	100% after deductible	80% after deductible	50% after deductible

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Organ Transplants	100% after deductible	80% after deductible	50% after deductible
• Donor expenses limited to a maximum of $10,000 per transplant	100% after deductible	80% after deductible	50% after deductible
• Reasonable lodging, meals and transportation expenses for the covered recipient and one other individual, limited to $150 per day and $10,000 per transplant.	100% after deductible	100% after deductible	100% after deductible
All Other Covered Charges	100% after deductible	80% after deductible	50% after deductible
Note: Covered expenses rendered by a Non-Network provider: • for a Covered Person while traveling outside the Network service area; • for a Full-Time Student attending school outside the Network service area; • for a Covered Person residing outside the Network service area; will be reimbursed at the Non-Network level of benefits.			

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS	PRESCRIPTION DRUG PROGRAM PAYS
Drugs available only through the Prescription Drug Program	
Retail (greater of 34-day supply or 100 unit dose)	100% after 25% Copay – Generic 25% Copay – Brand Name 25% Copay – Brand Name Non-Preferred Drug
Mail Order (greater of 90-day supply or 300 units dose)	100% after 25% Copay – Generic 25% Copay – Brand Name 25% Copay – Brand Name Non-Preferred Drug
Specialty Medications	100% after 25% Copay and with a $2,500 out-of-pocket maximum Per Calendar Year

Prescription drug coverage for members is administered by EnvisionRx, which is a pharmacy benefits manager. EnvisionRx provides a nationwide network of participating pharmacies and also provides a drug formulary. The EnvisionRx prescription drug formulary is divided into "tiers." The presence of a drug on this formulary does not guarantee coverage. The drugs listed on the EnvisionRx formulary are subject to change. For additional information go to www.envisionrx.com or call 1-833-684-7258.

Coverage for generic and name brand medications above $350 and specialty medications are only applicable if patient advocacy fails to provide a patient assistance program. Patient assistance comes from a variety of sources, including manufacturer assistance programs, copay cards, grants, and mail order pharmacies. The plan may cover the cost of patient assistance options so that your out of pocket cost will not exceed the cost under the pharmacy benefit. The plan may also allow for a 60-day grace period for urgent medications to allow time to complete the patient assistance process. Prior authorization is required on all specialty medications.