CARLE FOUNDATION HEALTH PLAN

PPO SCHEDULE OF BENEFITS

1/1/2024

Lifetime Maximum Benefits	**Preferred Provider & Non-Preferred Provider (Combined)**
Individual Lifetime Maximum Benefit	Unlimited
Infertility	$25,000 per Covered Person
Temporomandibular Joint (TMJ) Disorder	$5,000 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Beneficiary of a welfare benefit plan sponsored by the Group and is not intended to suggest benefits beyond an individual's termination date.

Plan Year Maximum Benefits	**Combined Preferred & Non-Preferred Provider**
Inpatient Rehabilitation and Skilled Nursing Care	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (Occupational, speech and physical therapies)	60 visits per Covered Person (all therapies combined)
Chiropractic Services (Includes all Chiropractic Services)	$750 per Covered Person
Retail Prescription Drugs	Unlimited
Home Health Care	100 visits per Covered Person
Smoking Cessation Products	One product per 12-month period, per Covered Person
Smoking Cessation Program	One program in a 12-month period, per Covered Person

Plan Year Deductibles	**Preferred Provider**	**Non-Preferred Provider**
Single	$1000	$2,000
Family	$3,000	$6,000

Deductibles apply to all covered services except for the following preferred provider benefits: office visits, virtual visits, outpatient mental health and substance abuse, outpatient lab, radiology and advanced radiology, annual physicals, preventative wellness benefits, well child care, routine eye exams, prescriptions drugs and specialty prescription drugs. A new Deductible will apply each Plan Year. Any combination of family members may satisfy the family deductibles.

Plan Year Out-of-Pocket Maximum	**Preferred Provider**	**Non-Preferred Provider**
Single	$4,000	$25,000
Family	$12,000	$75,000

All Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum amount except for charges over the Maximum Allowable Charge.

Preauthorization Penalty	**Preferred Provider***	**Non-Preferred Provider**
Failure to Preauthorize	$0	50%

Failure to preauthorize specified services outlined in the Preauthorization section of your Summary Plan Description (SPD) may result in the Preauthorization penalty for Services.

*If using an extended network provider (FirstHealth Network), failure to preauthorize specified services outlined in the Preauthorization section of your Summary Plan Description (SPD) may result in the 50% Preauthorization penalty for Services

Inpatient Services/Benefits	**You Pay Preferred Provider**	**You Pay Non-Preferred Provider**
Physician Services	20% Coinsurance after deductible	50% Coinsurance after deductible
Hospital Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Rehabilitation and Skilled Nursing Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Hospice Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Human Organ Transplant	20% Coinsurance after deductible	Not covered
Mental Health Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Abuse Treatment	20% Coinsurance after deductible	50% Coinsurance after deductible

Outpatient Services/Benefits		
Virtual Visits (MD Live)	Visits 1-3: $0 copayment (Deductible waived) Visits 4 (+): $20 copayment (Deductible waived)	Not Covered
Office Visit-Primary Care	$20 (Deductible waived)	50%, Coinsurance after deductible
Office Visit-Specialty Care	$40 (Deductible waived)	50% Coinsurance after deductible
Routine Prenatal Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Annual Physicals (one routine preventive visit is covered per plan year, any additional visits are subject to office visit coinsurance)	0% (Deductible waived)	50% Coinsurance after deductible
Wellness Benefit Program: **Be Healthy Wellness	0% (Deductible waived)	50% Coinsurance after deductible
Well-Child Care	0% Coinsurance (Deductible waived)	50% Coinsurance after deductible
Routine Eye Exams	$40 (Deductible waived)	50% Coinsurance after deductible
Outpatient Surgery	20% Coinsurance after deductible	50% Coinsurance after deductible

****Outpatient Lab Services	$50 (Deductible waived)	50% Coinsurance after deductible
****Outpatient Radiology	$100 (Deductible waived)	50% Coinsurance after deductible
****Outpatient Advanced Radiology (CT Scan ,PET Scan and MRI)	$250 (Deductible waived)	50% Coinsurance after deductible
Mental Health Care	$20 (Deductible waived)	50% Coinsurance after deductible
Substance Abuse Treatment	$20 (Deductible waived)	50% Coinsurance after deductible
Home Health Care/Home Infusion	20% Coinsurance after deductible	50% Coinsurance after deductible
Hospice Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Rehabilitative Therapy Services (Occupational, speech and physical therapies)	20% Coinsurance after deductible	50% Coinsurance after deductible
Emergency Transportation	$200 copay Deductible, then 20% Coinsurance	$200 copay Deductible, then 20% Coinsurance (In-Network benefits apply)
Emergency Room Services	Visits 1-2: $200 copay, deductible, then 20% Visits 3 (+): $500 copay, deductible, then 20% (per member)	Visits 1-2: $200 copay, deductible, then 20% Visits 3 (+): $500 copay, deductible, then 20% (per member) (In-Network benefits apply)
Urgent Care	20% Coinsurance after deductible	20% Coinsurance after deductible (In-Network benefits apply)
Durable Medical Equipment and Prosthetic Devices	20% Coinsurance after deductible	50% Coinsurance after deductible
TMJ Disorder	20% Coinsurance after deductible	50% Coinsurance after deductible
*Oral Surgery (Includes surgical tooth extractions)	20% Coinsurance after deductible	50% Coinsurance after deductible
Chiropractic Services (Included all Chiropractic services)	20% Coinsurance after deductible	20% Coinsurance after deductible (In-Network benefits apply)
Infertility Services (Enhanced Infertility services)	50% Coinsurance after deductible	50% Coinsurance after deductible
Other Covered Services	20% Coinsurance after deductible	50% Coinsurance after deductible

NOTES:
* Oral surgery includes surgical tooth extractions and must be performed by a Carle affiliated oral surgeon for members residing within a 35 mile radius of 61801 for the Preferred Provider reimbursement level/benefits to apply.

Updated 10.3.22

** For a complete listing of services covered under the Be Healthy Wellness Benefit, please contact Customer Service at 1-800-322-7451.
***For members with one or more chronic conditions as determined by Medical Management.
**** These co-payment amounts do not include services performed as an In-patient, in Observation, Ambulatory settings or the Emergency room.

Pharmacy Benefits 30 Day Supply	**You Pay Preferred Provider**	**You Pay Non-Preferred Provider**
	Tier 1: Preferred Generic $0	Not Covered
	Tier 2: Non-Preferred Generic $10	Not Covered
	Tier 3: Preferred Brand $40	Not Covered
	Tier 4: Non-Preferred Brand $60	Not Covered
	*Tier 5: Preferred Specialty 30%	Not Covered
	*Tier 6: Non-Preferred Specialty 30%	Not Covered
Pharmacy Benefits 90 Day Supply	**You Pay Preferred Provider**	**You Pay Non-Preferred Provider**
	Tier 1: Preferred Generic $0	Not Covered
	Tier 2: Non-Preferred Generic $27.50	Not Covered
	Tier 3: Preferred Brand $110	Not Covered
	Tier 4: Non-Preferred Brand $165	Not Covered

NOTES:
***Specialty Prescription Drugs are administered through Carle Specialty Pharmacy. For questions or assistance with obtaining Specialty Prescription Drugs, contact Carle Specialty Pharmacy at 217-383-8700, 8a.m. to 5p.m. weekdays.**

Retail and specialty prescription drugs may be prescribed by a Non-Preferred Provider but must be dispensed at a Preferred pharmacy or provided by a Preferred Provider.

Your Non-Preferred Provider Coinsurance is based on the Maximum Allowable Charge. In addition to the Coinsurance, you also pay any charges in excess of the Maximum Allowable Charge. Amounts over the Maximum Allowable Charge do not apply to the Out-of-Pocket Maximum.

Preferred Provider Coinsurance, if any, is based on the allowed or discounted amount.