

CARLE FOUNDATION HEALTH PLAN
QHDHP SCHEDULE OF BENEFITS
1/1/2024

Lifetime Maximum Benefits	Preferred Provider & Non-Preferred Provider Combined
Individual Lifetime Maximum Benefit	Unlimited
Infertility	\$25,000
Temporomandibular Joint (TMJ) Disorder	\$5,000
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
Outpatient Rehabilitative Therapy Services (Occupational, speech and physical therapies)	60 visits (treatment combined)
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
Chiropractic Services (All Chiropractic Services)	\$750 per covered person
Home Health Care	100 visits per Covered Person

Plan Year Deductibles (Aggregate)	Preferred Provider	Non-Preferred Provider
Single	\$2,000	\$4,000
Family	\$4,000	\$8,000

Deductibles apply to all covered services except preferred provider annual physicals, preferred provider preventative wellness benefits, and preferred provider well child care. A new Deductible will apply each Plan Year. Any combination of family members may satisfy the family deductibles.

Aggregate deductible definition - If one person is on the plan, he or she contributes to a single deductible. If more than one person is on the plan, they contribute to the family deductible.

Plan Year Out-of-Pocket Maximum	Preferred Provider	Non-Preferred Provider
Single	\$5,500	\$25,000
Family	\$11,000	\$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		
Office Visit-Primary Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Office Visit-Specialty Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Virtual Visits (MD Live)	20% Coinsurance after deductible	Not Covered
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% (Deductible waived)	50% Coinsurance after deductible
Routine Eye Exams	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Surgery	20% Coinsurance after deductible	50% Coinsurance after deductible
Diagnostic Testing (X-rays and laboratory services)	20% Coinsurance after deductible	50% Coinsurance after deductible

Mental Health Care	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Abuse Treatment	20% Coinsurance after deductible	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

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.

** For a complete listing of services covered under the Preventative Wellness benefit, please contact Customer Service at 1-800-322-7451.

***For members with one or more chronic conditions as determined by Medical Management.

Outpatient Services/Benefits	You Pay Preferred Provider	You Pay Non-Preferred Provider
Rehabilitative Therapy Services (Occupational, speech and physical therapies)	20% Coinsurance after deductible	50% Coinsurance after deductible
Emergency Transportation	20% Coinsurance after deductible	20% Coinsurance after deductible (In-Network benefits apply)
Emergency Room Services	Visits 1-2: 20% after deductible Visits 3(+): 30% after deductible (per member)	Visits 1-2: 20% after deductible Visits 3(+):30% after deductible (per member)
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 (All Chiropractic Services)	20% Coinsurance after deductible	20% Coinsurance after deductible (In-Network benefits apply)
Infertility Services (Enhanced Infertility)	50% Coinsurance after deductible	50% Coinsurance after deductible
Other Covered Services	20% Coinsurance after deductible	50% Coinsurance after deductible

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 \$80	Not Covered
	*Tier 5: Preferred Specialty 20%	Not Covered
	*Tier 6: Non-Preferred Specialty 50%	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 \$220	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 is based on the allowed or discounted amount.