Base Coverage

Base Coverage is a qualifying high deductible health plan that meets the federal government's criteria under Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 in regard to establishing a Health Savings Account (HSA). HSAs are portable, interest-bearing, funded accounts that provide for tax-free savings for medical expenses. HSAs allow individuals to pay for current qualified medical expenses and save for future qualified medical expenses on a tax-free basis. The Plan does not offer or administer HSA accounts. However, participants in Base Coverage may independently secure an HSA.

Summary of Base Coverage Benefits

This is only a summary of the benefits under Base Coverage. It does not provide all details and provisions of the Plan. Some limitations and exclusions apply and can be found within this *Plan Document*. All benefits are subject to the calendar year deductible unless otherwise noted in the *Covered Services* section. There are two tiers of coverage: Individual and Family.

Individual Coverage	**Network**	**Out-of-Network**
Calendar Year Deductible	$1,800	
Preventive Medications Deductible (Other medications are subject to Calendar Year Deductible)	$75	
Coinsurance Maximum	$3,000	$4,000
Out-of-Pocket Limit	$6,500	N/A
Family Coverage	**Network**	**Out-of-Network**
Calendar Year Deductible	$3,000	
Preventive Medications Individual Deductible (Other medications are subject to Calendar Year Deductible)	$75	
Coinsurance Maximum	$5,500	$7,500
Out-of-Pocket Limit (In no event shall any one individual with family coverage exceed $6,500 out-of-pocket expenses for covered network expenses.)	$13,000	N/A
Telehealth Minor Medical Care Visit	You pay $10 copayment subject to deductible	Not Covered
Telehealth Dietitian Services Visit	You pay $10 copayment subject to deductible	Not Covered
Telehealth Mental Health Care Visit	You pay 20%	Not Covered
Specialty Physician/Health Care Professional Services	You pay 20%	You pay 40%
Inpatient Hospital – Services must be certified as medically necessary by Kepro to be covered by the Plan (except for routine maternity delivery).	You pay 20%	You pay 40%
Outpatient Hospital Services	You pay 20%	You pay 40%
Emergency Room – Services are subject to a $50 copayment for the first visit and a $200 copayment for each subsequent visit in addition to the deductible and coinsurance. Copayment is waived if admitted.	You pay 20%	You pay 20%
X-Rays, Laboratory	You pay 20%	You pay 40%

Outpatient MRI/MRA/CAT/CTA Scans	You pay 20%	You pay 40%
Adult Wellness/Preventive Services	Plan pays 100%	Not Covered
Maternity – Specified prenatal care and network routine physician delivery covered at 100% subject to completion of the Maternity Management Program. *Note: Benefits are limited for dependent children.*	You pay 20%	You pay 40%
Maternity – Hospital; Other Services *(Not available for dependent children.)*	You pay 20%	You pay 40%
Well-Newborn Nursery Care	Plan pays 100%	Not Covered
Well-Child Office Visits and Routine Tests	Plan pays 100%	Not Covered
Well-Child Routine Immunizations	Plan pays 100%	Not Covered
Chiropractic Services – Manipulative therapy services - Limited to a maximum of 30 visits per participant per calendar year.	You pay 20%	You pay 40%
Accidental Injury to Natural Teeth and TMJ Services – Coverage is subject to the network coinsurance/copayment maximum. TMJ services are limited to a lifetime maximum of $5,000.	You pay 20%	You pay 20%

Participants in the Base Coverage will be charged the full allowable amount until the applicable deductible is met. Prescription medications are subject to the applicable deductible and the following copayments:

	Retail & Specialty Pharmacies			**Home Delivery**
Prescription Drug Type	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Preferred Generic Drug	$12	$24	$36	$24
Non-preferred Generic Drug	$30	$60	$90	$60
Preferred Brand Drug*	$45	$90	$135	$90
Non-preferred Brand Drug*	$100	$200	$300	$200
Specialty Drug	$100	N/A	N/A	N/A

***Generic mandate applies to brand drugs purchased when a generic is available.** If a participant purchases a covered brand drug for which a generic equivalent is available, the participant will pay the difference in the cost of the brand and the generic drug, plus the applicable brand copayment amount.

Individual Preventive Medications Deductible

Certain preventive medications such as anticoagulants, antiarrhythmics, antihyperlipidemics, antidepressants and diabetes medications are only subject to the preventive medications deductible. If the Base Coverage calendar year deductible is already met, a participant does not also have to meet the preventive medications deductible. Once either deductible is met, participants will pay the standard prescription drug copayments for certain preventive medications, see *Prescription Drug Program*.

Diabetes Related Prescriptions and Supplies Copayments	Retail Pharmacies			Diabetic Management Program
	1-30 Day Supply	31-60 Day Supply	61-90 Day Supply	90 Day Supply (or less)
Testing Supplies:				
Preferred Brand	$12	$24	$36	$24
Non-preferred Brand	$45	$90	$135	$90
Insulin Needles/Syringes	$12	$24	$36	$24
Glucagon	$12	$24	$36	$24
Insulin	$12	$24	$36	$24

Calendar Year Deductible – Individual Base Coverage

The calendar year deductible is the amount of covered expenses a participant must pay each year before the Plan begins to pay its share of covered expenses. Covered medical and prescription drug expenses apply toward the calendar year deductible, unless otherwise indicated. Once the calendar year deductible has been met, the Plan pays its portion of the allowable charge for covered expenses, and the participant pays prescription drug copayments for covered prescription drugs and a percentage of the allowable charge for covered medical expenses.

Calendar Year Deductible – Family Base Coverage

Family coverage applies when an enrollee (active employee, retiree, surviving spouse or COBRA participant) has one or more covered dependents. If an enrollee has family coverage, there is no separate high deductible for each covered individual in the family. Covered medical and prescription drug expenses apply toward the family calendar year deductible, unless otherwise indicated. Medical services and prescription drugs will not be paid for any participants in the family until the family deductible has been satisfied. However, in no event shall an individual's annual out-of-pocket costs exceed $6,500. The family deductible also applies when both husband and wife are covered separately as enrollees, one of the enrollees has dependent coverage, and both are enrolled in Base Coverage.

If both husband and wife are covered employees, one carries dependent coverage, and only one of them elects Base Coverage, calendar year deductibles and coinsurance amounts are not shared. If both husband and wife are covered employees with employee-only coverage, and both elect Base Coverage, the calendar year deductible and coinsurance amounts are not shared.

The following expenses do not count toward the individual or family calendar year deductible:

- Telehealth provider visit copayments
- Emergency room copayments
- Prescription drug copayments
- Utilization review penalties
- Generic drug differential amounts
- Expenses in excess of the allowable charge
- Expenses in excess of Plan maximum limits
- Services not covered by the Plan
- Services not considered medically necessary

Coinsurance – Base Coverage

Once the applicable deductible has been met, the Plan pays a portion of the allowable charge for covered medical expenses. The participant pays the remainder in the form of coinsurance.

Any fees charged by an out-of-network provider that are more than the allowable charge are not part of the coinsurance amount. The Plan will not pay any portion of these charges.

Do these expenses count toward the Coinsurance Maximum?

YES	NO
• Coinsurance paid for hospital inpatient services • Coinsurance paid for other covered medical expenses	• Calendar year deductible • Preventive medications deductible • Telehealth provider visit copayments • Emergency room copayments • Prescription drug copayments • Generic drug differential amounts • Utilization review penalties • Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Services not covered by the Plan • Services not considered medically necessary

Coinsurance Maximum – Individual Base Coverage

The coinsurance maximum is the maximum amount that an enrollee with individual coverage has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100 percent of the allowable charge. The coinsurance maximum provides participants protection against catastrophic health care expenses. The amounts paid toward meeting the calendar year medical deductible, preventive medications deductible, telehealth provider visit copayments, emergency room copayments and prescription drug copayments do not count toward satisfying the coinsurance maximum.

The initial $3,000 of coinsurance is applied to both the network and out-of-network coinsurance maximum. After the initial $3,000 has been met, only the coinsurance amount for services rendered by out-of-network providers will be applied to the additional $1,000 out-of-network coinsurance. Once the annual coinsurance maximum is met, the Plan pays 100 percent of the allowable charge for covered medical expenses for the remainder of that calendar year, except as otherwise specified.

Coinsurance Maximum – Family Base Coverage

The coinsurance maximum is the maximum amount that a family has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100 percent of the allowable charge. If an enrollee has family coverage, there is no separate coinsurance maximum for each individual. The family coinsurance maximum also applies when both husband and wife are covered separately as enrollees, one of the enrollees has family coverage, and both are enrolled in Base Coverage. The amount paid toward meeting the calendar year medical deductible, preventive medications deductible, telehealth provider visit copayments, emergency room copayments, and prescription drug copayments do not count toward satisfying the coinsurance maximum.

The initial $5,500 of coinsurance is applied to both the network and out-of-network coinsurance maximum. After the initial $5,500 has been applied, only the coinsurance amount for services rendered by out-of-network providers will be applied to the additional $2,000 out-of-network coinsurance maximum.

Once the annual coinsurance maximum is met, the Plan pays 100 percent of the allowable charge for covered medical expenses for the remainder of that calendar year, unless otherwise specified. However, in no event shall an individual's annual out-of-pocket costs exceed $6,500 for covered network expenses.

Do these expenses count toward the Coinsurance Maximum?

YES	NO
• Coinsurance paid for hospital inpatient services • Coinsurance paid for other covered medical expenses	• Calendar year deductible • Preventive medications deductible • Telehealth provider visit copayments • Emergency room copayments • Prescription drug copayments • Generic drug differential amounts • Utilization review penalties • Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Services not covered by the Plan • Services not considered medically necessary

Out-of-Pocket Limit – Individual Base Coverage

The out-of-pocket limit is the maximum amount that a participant with individual coverage has to pay for network deductible, coinsurance and copayments for covered medical and prescription drug expenses in a calendar year before benefits will be paid at 100 percent. The out-of-pocket limit protects a participant from having to pay catastrophic medical bills in a given year.

Out-of-Pocket Limit – Family Base Coverage

The out-of-pocket limit is the maximum amount that a family has to pay for network deductible, coinsurance and copayments for covered medical and prescription drug expenses in a calendar year before benefits will be paid at 100 percent. The out-of-pocket maximum protects a family from having to pay catastrophic medical bills in a given year. In no event shall an individual's annual out-of-pocket costs exceed $6,500.

Do these expenses count toward the Out-of-Pocket Limit?

YES	NO
• Network calendar year deductibles • Preventive medications deductible • Prescription drug copayments • Telehealth provider visits copayments • Emergency room copayments • Network coinsurance paid for hospital inpatient services • Network coinsurance paid for other covered medical expenses	• Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Utilization review penalties • Services not covered by the Plan • Generic drug differential amounts • Services not considered medically necessary

Telehealth Provider Visit Copayment

There is a $10 copayment for network telehealth primary care providers and registered dietitians. The copayment applies once the annual deductible has been met. Behavioral health visits are subject to the coinsurance and deductible.

Select Coverage

Summary of Select Coverage Benefits

This is only a summary of the medical benefits under Select Coverage. It does not provide all details and provisions of the Plan. Some limitations and exclusions apply and can be found within this *Plan Document*. All medical benefits are subject to the calendar year deductible unless otherwise noted in the *Covered Services* section.

Individual Coverage	**Network**	**Out-of-Network**
Calendar Year Medical Deductible	$1,800	$2,300
Individual Prescription Drug Deductible	$75	
Medical Coinsurance Maximum	$3,000	$4,000
Out-of-Pocket Limit	$6,500	N/A
Family Coverage	**Network**	**Out-of-Network**
Family Calendar Year Medical Deductible	$3,600	$4,600
Family Out-of-Pocket Limit	$13,000	N/A
Telehealth Minor Medical Care Visit	You pay $10 copayment not subject to deductible	Not Covered
Telehealth Dietitian Services Visit	You pay $10 copayment not subject to deductible	Not Covered
Telehealth Mental Health Care Visit	You pay 20%	Not Covered
Primary Care Office Visit	You pay $25 copayment not subject to deductible	You pay 40%
Other Primary Care Services (labs, x-rays) provided in office	You pay 20% not subject to deductible	You pay 40%
Other Primary Care Services (labs, x-rays) provided outside office	You pay 20%	You pay 40%
Specialty Physician/Health Care Professional Services	You pay 20%	You pay 40%
Inpatient Hospital – Services must be certified as medically necessary by Kepro to be covered by the Plan (except for routine maternity delivery).	You pay 20%	You pay 40%
Outpatient Hospital Services	You pay 20%	You pay 40%
Emergency Room – Services are subject to a $50 copayment for the first visit and a $200 copayment for each subsequent visit in addition to the deductible and coinsurance. The copayment is waived if admitted.	You pay 20%	You pay 20%
Adult Wellness/Preventive Services	Plan pays 100%	Not Covered
Maternity – Specified prenatal care and network routine physician delivery is covered at 100% subject to completion of the Maternity Management Program. *Note: Benefits are limited for dependent children.*	You pay 20%	You pay 40%

Maternity – Hospital; Other Services *(Not available for dependent children.)*	You pay 20%	You pay 40%
Well-Newborn Nursery Care	Plan pays 100%	Not Covered
Well-Child Office Visits and Routine Tests	Plan pays 100%	Not Covered
Well-Child Routine Immunizations	Plan pays 100%	Not Covered
Chiropractic Services – Manipulative therapy services limited to a maximum of 30 visits per participant per calendar year.	You pay 20%	You pay 40%
Accidental Injury to Natural Teeth and TMJ Services – Network benefits apply. TMJ services limited to a lifetime maximum of $5,000.	You pay 20%	You pay 20%

Prescription drug copayments for retail pharmacies and home delivery service are as follows:

	Retail and Specialty Pharmacies			**Home Delivery**
Prescription Drug Type	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Preferred Generic Drug	$12	$24	$36	$24
Non-preferred Generic Drug	$30	$60	$90	$60
Preferred Brand Drug*	$45	$90	$135	$90
Non-preferred Brand Drug*	$100	$200	$300	$200
Specialty Drug	$100	N/A	N/A	N/A

***Generic mandate applies to brand drugs purchased when a generic is available.** If a participant purchases a brand drug for which a generic equivalent is available, the participant will pay the difference in the cost of the brand and the generic drug, plus the applicable brand copayment amount.

Diabetes Related Prescriptions and Supplies Copayments	**Retail Pharmacies**			**Diabetic Management Program**
	1-30 Day Supply	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Testing Supplies:				
Preferred Brand	$12	$24	$36	$24
Non-preferred Brand	$45	$90	$135	$90
Insulin Needles/Syringes	$12	$24	$36	$24
Glucagon	$12	$24	$36	$24
Insulin	$12	$24	$36	$24

Individual Prescription Drug Deductible

In most cases, participants must first satisfy a separate prescription drug deductible each calendar year before the Plan will pay any of the cost for prescription drugs. The prescription drug deductible and copayment amounts will not apply toward satisfying the medical calendar year deductible or coinsurance maximum.

Calendar Year Medical Deductible – Individual Select Coverage

The calendar year deductible is the amount of covered medical expense a participant must pay each year before the Plan begins to pay its share of covered expenses. Once the calendar year deductible is met, the Plan pays a percentage of the allowable charge for covered medical expenses.

The initial $1,800 of covered medical expenses will apply to both the network and out-of-network deductible. After the initial $1,800 has been applied, only services rendered by an out-of-network provider will be applied to the additional $500 out-of-network deductible.

Calendar Year Medical Deductible – Family Select Coverage

Once a family has paid the family medical deductible in a calendar year, all covered participants in that family will have satisfied their individual medical deductible for that calendar year.

The family medical deductible also applies when both husband and wife are covered separately as enrollees, and both are enrolled in Select Coverage. No individual family member may contribute more than $1,800 to the network family medical deductible, or more than $2,300 to the out-of-network family medical deductible.

The initial $3,600 of covered expenses will apply to both the network and out-of-network family medical deductible. After the initial $3,600 has been applied, only services rendered by an out-of-network provider will be applied to the additional $1,000 out-of-network family medical deductible.

The following expenses do not count toward the calendar year medical deductible:

- Prescription drug deductible
- Primary care office visit copayments
- Telehealth provider visit copayments
- Emergency room copayments
- Prescription drug copayments
- Generic drug differential amounts
- Utilization review penalties
- Expenses in excess of the allowable charge
- Expenses in excess of Plan maximum limits
- Services not covered by the Plan
- Services not considered medically necessary

Coinsurance – Select Coverage

Once a participant has met the calendar year medical deductible, the Plan pays a portion of the allowable charge for covered medical expenses. The participant pays the remainder in the form of coinsurance.

Any fees charged by an out-of-network provider that are above the allowable charge are not part of the coinsurance amount. The Plan will not pay any portion of these charges.

Coinsurance Maximum – Individual Select Coverage

The individual medical coinsurance maximum is the maximum amount that each participant has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100 percent. The medical coinsurance maximum protects a participant from having to pay catastrophic medical bills in a given year. The amount paid toward meeting the calendar year individual and family medical deductibles does not count toward satisfying the medical coinsurance maximum.

The initial $3,000 of medical coinsurance is applied to both the network and out-of-network medical coinsurance maximums. After the initial $3,000 has been met, only the coinsurance amount for services rendered by out-of-network providers will be applied to the additional $1,000 out-of-network coinsurance. Once the annual medical coinsurance maximum is met, the Plan covers 100 percent of the allowable charge for covered medical expenses for the remainder of that calendar year, unless otherwise specified.

Do these expenses count toward the Coinsurance Maximum?

YES	NO
• Coinsurance paid for hospital inpatient services • Coinsurance paid for other covered medical expenses	• Calendar year deductibles • Family deductibles • Prescription drug deductible • Primary care office visit copayments • Telehealth provider visit copayments • Emergency room copayments • Prescription drug copayments • Generic drug differential amounts • Utilization review penalties • Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Services not covered by the Plan • Services not considered medically necessary

Out-of-Pocket Limit – Individual Select Coverage

The out-of-pocket limit is the maximum amount that a participant with individual coverage has to pay for network deductible, coinsurance, and copayments for covered medical expenses in a calendar year before benefits will be paid at 100 percent. The out-of-pocket limit protects a participant from having to pay catastrophic medical bills in a given year.

Out-of-Pocket Limit – Family Select Coverage

The out-of-pocket limit is the maximum amount that a family has to pay for network deductible, coinsurance and copayments for covered medical expenses in a calendar year before benefits will be paid at 100 percent. The network out-of-pocket maximum protects a family from having to pay catastrophic medical bills in a given year. There is no family out-pocket-limit for out-of-network services.

Do these expenses count toward Out-of-Pocket Limit?

YES	NO
• Network calendar year deductibles • Office visit copayments • Telehealth provider visit copayments • Prescription drug deductible • Prescription drug copayments • Emergency room copayments • Network coinsurance paid for hospital inpatient services • Network coinsurance paid for other covered medical expenses	• Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Utilization review penalties • Services not covered by the Plan including all those found in the *Limitations and Exclusions* section • Generic drug differential amounts • Services not considered medically necessary

Primary Care Office Visit Copayment – Select Coverage

An office visit copayment is available under Select Coverage and only applies to the following network primary care services: Family Practice, General Practice, Gynecology, Internal Medicine, Pediatric Medicine, including Nurse Practitioner, Physician Assistant and Registered Dietitian. Copayments apply to the provider's office visit charge only and are not subject to the deductible or coinsurance requirements. Charges for services rendered in the provider's office such as lab work and x-rays are applied a 20 percent coinsurance, not subject to the deductible. Lab work and other tests performed outside the provider's office are subject to regular Plan benefits. Out-of-network provider office visits are subject to the normal out-of-network deductibles and coinsurance rates.

Helpful Tip: Network providers agree not to charge any amount above the Plan's allowable charge for covered services.

Telehealth Provider Visit Copayment

There is a $10 copayment for network telehealth primary care providers and registered dietitians. Mental health care visits are subject to the coinsurance and deductible.