

MED PERFORMANCE

5000 HSA

Schedule of Benefits & Plan Design Medical Services Deductible Information		
Deductible	Participating Providers	Non-Participating Providers
	(In-Network)	(Out of Network)
Individual	\$5,000	\$10,000
Familly	\$10,000	\$20,000
Out of Pocket Information		
Out of Pocket Maximum	Participating Providers	Non-Participating Providers
	(In-Network)	(Out of Network)
Individual	\$6,550	\$13,100
Familly	\$13,100	\$26,200
Coinsurance Information		
Coinsurance	Participating Providers	Non-Participating Providers
	(In-Network)	(Out of Network)
After Deductible	20%	40%
UNLIMITED ANNUAL MAXIMUM BENEFIT		

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Schedule of Benefits

The following table represents the medical services currently covered under the **5000 HSA** plan as well as the permitted interval and any requirements of such medical services.

Plan Provisions	Prior Auth Required ¹	Participating Providers	Non-Participating Providers	Plan Limitations & Intervals
		(In-Network)	(Out of Network)	
Preventive & Wellness Services		Member Pays		
(Non-Hospital Based)	No	\$0 Copay	Deductible & Coinsurance	
(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member	
Physician Services		Member Pays		
Telemedicine Services	No	\$0 Copay	N/A	Provided through Rely MD
Office Visit - Primary Care	No	20% Coinsurance after deductible	40% Coinsurance after deductible	
Specialist Office Visit	No	20% Coinsurance after deductible	40% Coinsurance after deductible	
Other Physicians Services performed in the office (Non Surgical)	No	20% Coinsurance after deductible	40% Coinsurance after deductible	
Other Physicians Services performed in the office (Surgical)	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Service may need pre-certification.

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Plan Provisions	Prior Auth Required ¹	Participating Providers (In-Network)	Non-Participating Providers (Out of Network)	Plan Limitations & Intervals
Urgent Care	No	20% Coinsurance after deductible	40% Coinsurance after deductible	
Acupuncture	No	20% Coinsurance after deductible	40% Coinsurance after deductible	20 visits per year.
Chiropractic Services	No	20% Coinsurance after deductible	40% Coinsurance after deductible	20 visits per year.
HOSPITAL/FACILITY SERVICES		Member Pays		
Hospital Inpatient	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.
Inpatient Physician & Ancillary Services	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.
Inpatient Surgery – Physician Charges	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.
Outpatient Hospital or Free-Standing Facility Services and Surgery	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.
Anesthesia	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.

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Plan Provisions		Prior Auth Required 1	Participating Providers (In-Network)	Non-Participating Providers (Out of Network)	Plan Limitations & Intervals
EMERGENCY SERVICES			Member Pays		
Emergency Room Facilities and Covered Services		No	20% Coinsurance after deductible	20% Coinsurance after deductible	Some Emergency Services may need pre-certification.
Ambulance / Emergency Medical Transportation		No	20% Coinsurance after deductible	20% Coinsurance after deductible	Some Emergency Services may need pre-certification.
Diagnostic Services			Member Pays		
Laboratory Services	Freestanding Laboratory	No	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Laboratory / Diagnostics	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Diagnostic Services may need pre-certification.
Radiology		No	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Diagnostic Services may need pre-certification.
CT/MRI/MRA/PET Scan		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Diagnostic Services may need pre-certification.
Maternity & Infertility Services			Member Pays		
Office Visit - OBGYN		No	20% Coinsurance after deductible	40% Coinsurance after deductible	
Pregnancy: Childbirth/Delivery		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Procedures may need pre-certification.
Infertility		Yes	Not Covered 100% paid by Member	Not Covered 100% paid by Member	

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Plan Provisions	Prior Auth Required ¹	Participating Providers (In-Network)	Non-Participating Providers (Out of Network)	Plan Limitations & Intervals
Mental Health Services		Member Pays		
Outpatient Mental Health	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	
Inpatient Mental Health	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	
Other Services		Member Pays		
Injections	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Injections may need pre-certification.
Adult Eye Exam	No	20% Coinsurance after deductible	40% Coinsurance after deductible	1 visit per year.
Cardiac Rehabilitation	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	36 visits per year. Some Rehabilitation may need pre-certification.
Durable Medical Equipment	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some Durable Medical Equipment may need pre-certification.
Habilitation Services	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	20 visits per year. Some Habilitation Services may need pre-certification.
Hearing Aids	No	Not Covered	Not Covered	
Home Health Care	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	60 visits per year. Some Home Health Care Services may need pre-certification.
Hospice Care	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Service may need pre-certification.
Other services	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Service may need pre-certification.
Private Duty Nursing	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Service may need pre-certification.

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Radiation and Chemotherapy		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Some service may need pre-certification.
Rehabilitation Services (occupational, physical, and speech therapy)		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	20 visits per year. Some Home Health Care Services may need pre-certification.
Skilled Nursing Facility		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	60 days per year.
Treatment for Chemical Abuse & Dependency	(In-Patient)	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Pre-certification Required.
Treatment for Chemical Abuse & Dependency	(Out-Patient)	Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Pre-certification Required.
Inpatient Care Substance Abuse Detoxification Facility (7 Day Maximum)		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Pre-certification Required.
Colonoscopy (Diagnostic Purposes)		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Pre-certification Required.
Transplant - Facility		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Pre-certification Required.
Transplant - Physician and Anesthesiologist Charges during Inpatient Hospitalization		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Pre-certification Required.
Dialysis		Yes	20% Coinsurance after deductible	40% Coinsurance after deductible	Pre-certification Required.

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Pharmacy Benefits				
Plan Provisions		Member Pays		
		Participating Providers (In-Network)	Non-Participating Providers (Out of Network)	Plan Limitations & Intervals
Preventive Generic	(30 day supply)	\$0 Copay	Not Covered	If a Plan Participant requests a Brand or Specialty name drug when a Generic equivalent is available, then the Plan Participant must pay the Brand or Specialty name drug copayment plus the difference in cost between the Brand or Specialty name drug and the Generic drug. This expense will not apply to the maximum out-of-pocket amount.
	(90 day supply)	\$0 Copay	Not Covered	
Generic	(30 day supply)	\$15 Copay (After Deductible)	Not Covered	
	(90 day supply)	\$30 Copay (After Deductible)	Not Covered	
Preferred Brand	(30 day supply)	\$65 Copay (After Deductible)	Not Covered	
	(90 day supply)	\$130 Copay (After Deductible)	Not Covered	
Non-Preferred Brand	(30 day supply)	\$100 Copay (After Deductible)	Not Covered	
	(90 day supply)	\$200 Copay (After Deductible)	Not Covered	
Specialty	(30 day supply)	50% Coins. After Deductible	Not Covered	
	(90 day supply)	Not Covered	Not Covered	