RFP 22-004
Employee Benefits Consultant

ADDENDUM #2
Schedule of Benefits

This addendum is being issued to provide a copy of the Schedule of Benefits for the Base Plan and Premium Plan.

ACKNOWLEDGEMENT

It is the vendor's responsibility to ensure their receipt of all addenda, and to clearly acknowledge all addenda within their initial bid or proposal response in the space provided on the Submittal Checklist included in the original solicitation document. Failure to do so may subject the bidder to disqualification.

CITY OF SEBRING BASE HDHP PLAN
SCHEDULE OF MEDICAL BENEFITS
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All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, and out-of-pocket maximums, if any.

Verification of Eligibility Call 1 (800) 845-7629 to verify eligibility for Plan benefits **before** the charge is incurred.

TIME LIMIT TO FILE A CLAIM: REQUESTS FOR PAYMENT OR REIMBURSEMENT MADE BY A COVERED PERSON OR HEALTHCARE PROVIDER MUST BE RECEIVED BY THE PLAN SUPERVISOR WITHIN 365 DAYS FROM THE DATE OF SERVICE TO BE CONSIDERED TIMELY FILED. PLEASE MAKE YOUR PROVIDER AWARE OF THE TIMELY FILING LIMIT.

The Schedule of Benefits highlights and summarizes some provisions of the Plan that describe amounts you will need to pay as cost-sharing amounts, and some things that may limit the amount of benefits you can receive under the Plan. This section of the document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. Refer to the covered Medical Benefits and Plan Exclusions sections of the summary plan description for more details. The meanings of these capitalized terms are in the Defined Terms section of this document.

This Plan does not pay all medical expenses. It pays certain expenses under certain circumstances. For an expense to be "covered" under this Plan, a number of requirements must be met, including –

- The person receiving the service giving rise to the expense must be a covered individual;
- The service giving rise to the expense must be a covered service;
- The expense for the covered service must meet the requirements of a covered charge; and
- The covered individual must pay any applicable cost-sharing amounts.

REQUIRED PRECERTIFICATION (PRIOR AUTHORIZATION)

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The covered charges for certain covered services may be reduced or entirely excluded if the covered individual does not receive pre-certification (pre-treatment authorization) for the specific covered service. Pre-certification is always the covered individual's responsibility. Any amounts for which a covered individual is financially responsible due to a failure to follow the pre-certification procedures are considered outside of the scope of the Plan, and are not counted to the satisfaction of the Deductible or the Out-of-Pocket Maximum.

Generally, providers notify the plan before they provide these services to you. However, there are some benefits for which you are responsible for notifying the plan. This Plan has contracted with a Utilization Review Program and requires pre-certification on ALL Hospital confinements, as well as other Plan requirements as outlined in the Schedule of Benefits.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced. Before hospital admission or surgery (outside the physician's office) or for other services as specified in your plan your physician must call for pre-treatment authorization (pre-certification). Note, that if a Covered Person received Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency.

Please call Anchor Benefit Consulting, Inc. for pre-certification at 1-800-845-7629 or 407-667-8766.

Emergency hospital admissions must be reported within 72 hours or by the next regular working day following admission. The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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Services for which you must pre-certify are identified below and in the Schedule of Benefits table.

Inpatient Pre-Certification:

Inpatient Acute Care (Services rendered in a hospital setting not included in any other inpatient pre-cert category.)
Detox
Long term acute care
Rehabilitation
Routine and High Risk Maternity
(routine only if inpatient stay exceeds federal requirements)
Skilled Nursing Facility
Inpatient Mental Health & Substance Abuse
(Hospital/Residential/partial hospitalization)

Outpatient Pre-Certification:

Cochlear Implants (osseointegrated, cochlear or auditory brain stem implant)
Dialysis
Durable Medical Equipment
Experimental/Investigational/Unproven Procedures
Home Health Care
Home Infusion Therapy (immunotherapy, continuous medications, hydration, total parenteral nutrition, pain management)
Injectable medications (immune globulin, drugs for factor deficiencies, interferon, Rituxan, some chemotherapeutic agents)
Orthotics and Prosthetics
Outpatient Procedures (not otherwise categorized, such as facial reconstruction, varicose vein treatment, blepharoplasty, rhinoplasty and breast reconstruction/reduction**)** Surgeries and procedures that may not be medically necessary.
Sleep Management Program (obstructive sleep apnea, diagnostic or therapeutic sleep studies)
Speech Therapy
Spinal Procedures (Allograft/osteopromotive material for spine surgery, osteotomy, percutaneous vertebroplasty, arthrodesis, laminectomy, vertebral corpectomy, destruction by neurolytic agent, laminotomy, facet joint nerve destruction, spinal cord decompression)
Therapeutic Radiology (Brachytherapy, proton beam therapy, radiotherapy)
Transplants (Adult or pediatric, living or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants; preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants; transplant-related travel and lodging)
Unlisted procedures (vascular surgery, miscellaneous DME, unclassified drugs/biologics including antineoplastics, lower extremity prosthesis)

******Observation level of care for stays less than 24 hours are not reviewed for medical necessity. Observation level of care can be approved for services over 24 hours, not to exceed 48 hours. Any stay lasting over 48 hours is considered inpatient acute care.

HEALTH CARE PROVIDERS

Under this Plan, covered individuals may receive different levels of coverage depending on where covered services are received. Generally, when covered services are received from an In-Network provider, the covered individual will receive the highest level of coverage (meaning the covered individual generally will be responsible for less of the cost). When covered services are received from an Out-of-Network provider, the covered individual generally will receive a lower level of coverage and be responsible for any amounts charged by the Out-of-Network provider above Usual and Customary Rates.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

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If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

To receive In-Network benefits, a Covered Person must receive treatment from a contracted health care provider. The Employer has selected the Cigna PPO network to offer health care services through specific Physicians, Hospitals and various other service providers.

IT IS THE RESPONSIBILITY OF THE COVERED PERSON TO CHOOSE PROVIDERS WITHIN THE NETWORK FOR MAXIMUM BENEFIT COVERAGE.

The Plan is a plan which contains a Preferred Provider Organization (PPO).

Medical PPO name: **Cigna PPO**
Address: P.O. Box 188061
Chattanooga, TN 37422-8061
Website: www.Cigna.com
Payor ID: **62308**

To confirm if a provider is In-Network, review the current provider directory, which can be found online when you register with www.myCigna.com. If you do not wish to register, you can also search for a provider by going to www.Cigna.com and clicking on “Find a Doctor, Dentist or Facility” at the top of the page and then selecting “Employer or school” under “How are you Covered?”. You will then be directed to the directory search page. Enter your address or zip code then choose your search method, Doctor by Type, Doctor by Name or Health Facilities. Thereafter, you may be asked to login/register or continue as a guest. If you continue as a guest, be sure to select your plan’s network by clicking on Continue. A list of networks will appear, select “PPO, Choice Fund PPO”. A list of your search criteria will appear. You can print the list by scrolling to the end of the listing and clicking on the “Print/Save PDF”. It is important you select the Plan’s network to ensure you are viewing the correct listing.

Under the following circumstances, the higher In-Network payment will be made for certain Out-of-Network services:

If a Covered Person has no choice of In-Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a Out-of-Network Provider at an In-Network facility.

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USUAL AND CUSTOMARY RATES

The Plan pays benefits based on covered charges, not actual charges. Covered charges cannot exceed the Usual and Customary Rates (UCR) of a covered service, as determined by the Plan. If an Out-of-Network provider charges more than the Usual and Customary Rates (as determined by the Plan), the covered individual is responsible for the amount in excess of the Usual and Customary Rates. This excess amount is considered outside the scope of the Plan and is not counted toward the satisfaction of the Deductible nor the Out-of-Pocket Maximum. The claims for the dental plan are paid according to UCR.

Enrolling for coverage under this Plan does not automatically guarantee services by a participating Provider. The list of participating Providers is subject to change. When a Provider no longer has a contract with a network, you must choose another physician among the remaining participating Providers to receive maximum benefit coverage.

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	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS	COMMENTS
Lifetime Dollar Maximum Amount: Unlimited for essential health benefits.			
ANNUAL DEDUCTIBLE AMOUNT, PER CALENDAR YEAR			
Individual	$2,500	$4,000	
Per Family Unit	$5,000	$8,000	No one person will pay more than his/her individual Deductible amount.
The Deductible is waived for In-Network Preventive Care, preventive drugs, office visits, diagnostic testing, advanced imaging, newborn care and other services as specified. Copayments do not apply to the Deductible.			
Coinsurance	20%	50%	Paid by Covered Person after satisfaction of Deductible, where applicable, unless stated otherwise.
ANNUAL MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Individual	$7,000	$10,000	
Per Family Unit	$14,000	$17,000	No one person will pay more than his/her individual Out-of-Pocket maximum amount.
The maximum Out-of-Pocket amount includes the Deductible, Copayments (health care service and outpatient prescription), and Coinsurance. After the maximum Out-of-Pocket amount has been satisfied, the Plan will pay 100% of eligible expenses up to the allowable charge for the remainder of the Calendar year.			
COVERED SERVICES AND BENEFIT AMOUNT			
PREVENTIVE CARE SERVICES			
Routine Wellness Services for Adults	Plan pays 100%	Plan pays 50% after Deductible	Limited to one routine physical exam/calendar year. Age and frequency limits may apply.
Standard Preventive Care shall be provided as required by applicable law if provided by a Network provider. Standard Preventive care for adults includes services with an “A” or “B” rating from the United States Preventive Services Task Force which includes physician office services, scopic procedures, lab, X-ray, or recommended screenings, routine physical exam, immunizations, and contraceptives. These services are based on your age, gender and other health factors. This is not an all-inclusive list. Mammograms must be over age 40 unless Medically Necessary and routine colonoscopies age 50+ unless Medically Necessary.			
Routine Wellness Services for Children	Plan pays 100%	Plan pays 50% after Deductible	Limited to one routine physical exam/calendar year. Age and frequency limits may apply.
Standard Preventive Care shall be provided as required by applicable law if provided by a Network provider. Standard Preventive care for children includes services with an “A” or “B” rating from the United States Preventive Services Task Force which includes physician office services, lab, X-ray, hearing tests, vision tests, or recommended screenings, routine physical exam and immunizations up to age 18. These services are based on age, gender and other health factors. This is not an all-inclusive list.			
PHYSICIAN SERVICES			
Physician Office Visit	$40 Co-pay/visit	Plan pays 50% after Deductible	Includes services billed from a Physician office setting.
Specialist Office Visit	$75 Co-pay/visit	Plan pays 50% after Deductible	Includes services billed from a Physician office setting.
Virtual Visits	$20 Co-pay/visit	Not Covered	Includes services billed from a Physician office setting.
Office Surgery	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Diagnostic Testing	Plan pays 80% Deductible Waived	Plan pays 50% after Deductible	Includes X-rays and lab testing in a Physician’s office setting.

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	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS	COMMENTS
EMERGENCY AND URGENT CARE SERVICES			
Urgent Care Center	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Ambulance Service	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible	Limited to ground/air transport to nearest facility
Emergency Room Visit/Includes Physician Care	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible	Emergency only
Emergency hospital admissions must be reported to Anchor Benefit Consulting (800-845-7629) within 72 hours or by the next regular working day following admission even if the patient is discharged within 72 hours of the admission.			
Non-Emergency Room Visit/Includes Physician Care	Plan pays 50% after Deductible	Plan pays 40% after Deductible	Applies to non-emergent use of ER
DIAGNOSTIC SERVICES			
Diagnostic Testing	Plan pays 80% Deductible Waived	Plan pays 50% after Deductible	Applies to independent facility and Hospital facility.
Advanced Imaging	Plan pays 80% Deductible Waived	Plan pays 50% after Deductible	Prior authorization required Applies to independent facility and Hospital facility.
Advanced Imaging includes: CT, MRI, MRA, PET, and nuclear scans. Myocardial perfusion imaging, cardiac blood pool imaging and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms.			
HOSPITAL SERVICES			
Pre-Admission Testing	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Inpatient Facility (Hospital room)	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
**Observation level of care for stays less than 24 hours are not reviewed for medical necessity. Observation level of care can be approved for services over 24 hours, not to exceed 48 hours. Any stay lasting over 48 hours is considered inpatient acute care.			
Intensive Care Unit	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
Outpatient Surgery	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
Physician/Surgeon Fees	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Skilled Nursing Facility	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required Limited to 60 days/calendar year
Organ Transplants	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
Must be medically necessary and non-experimental. The Cigna LifeSource Transplant Network must be used to gain access to the network of participating organ and tissue transplant centers. For more information, visit: www.cignalifesource.com.			
REHABILITATION THERAPY SERVICES			
Chiropractic Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Limited to 24 visits/calendar year.
Habilitation Services	Not Covered	Not Covered	
Physical Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Occupational Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Speech Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	

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	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS	COMMENTS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Inpatient Facility	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Residential Treatment	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Partial Hospitalization	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Outpatient Office Visit	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
MATERNITY AND ROUTINE NURSERY CARE SERVICES			
Pregnancy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required. See note below.
The attending Physician does not have to obtain prior authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. **Prior Authorization Required for Routine and High-Risk Maternity (routine only if inpatient stay exceeds federal requirements).**			
Birthing Center	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Newborn Nursery/Physician Care	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Paid under newborn's plan
OTHER COVERED MEDICAL SERVICES			
Ambulatory Surgical Center	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
Bariatric Surgery	Not Covered	Not Covered	
Bereavement Counseling	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Chemotherapy/Radiation	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Wig after Chemotherapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Covers charges associated w/initial purchase.
Cochlear Implants	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Dialysis	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Durable Medical Equipment & Supplies	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Hearing Aids/Exams	Not Covered	Not Covered	
Home Health Care Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required Limited to 40 visits/Calendar Year
Hospice Care	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Infertility	Not Covered	Not Covered	
Infusion Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Injectable Medications	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Certain injectables may require prior authorization such as immune globulin, drugs for factor deficiencies, interferon, Rituxan, and some chemotherapeutic agents.			
Jaw Joint/TMJ	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Oral Surgery	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Limited to Injury to or care of mouth, sound natural teeth and gums
Orthotics/Prosthetics	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required Ortho limited to one pair of shoes/Calendar Year

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	IN-NETWORK BENEFITS	**OUT-OF-NETWORK BENEFITS**	**COMMENTS**
Sleep Management	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required. Includes obstructive sleep apnea, diagnostic or therapeutic sleep studies.
All Other Covered Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization may be required for unlisted procedures.

CITY OF SEBRING BASE HDHP PLAN
SCHEDULE OF MEDICAL BENEFITS
EFFECTIVE JANUARY 1, 2021

PRESCRIPTION DRUG BENEFIT

Following is a brief summary of your prescription drug benefits. Co-payment and/or Coinsurance is determined by the tier to which CVS Caremark (drug formulary) has assigned the prescription drug. To view medicine history, track your spending, compare medicine costs and find lower-priced options, check for possible drug interactions, track your refills, and search for participating pharmacies, visit www.caremark.com or call Customer Care at 1-866-475-0056.

Note, products covered by the prescription drug benefit plan may change from time to time in accordance with CVS Caremark prescription management guidelines. Call CVS Caremark to ensure your specific medication is covered under the Plan. You can access CVS Caremark's "Ask a Pharmacist" online tool at Caremark.com, email a pharmacist or view online frequently asked questions.

PRESCRIPTION DRUG DEDUCTIBLE, PER CALENDAR YEAR			
Per Covered Person	**None**		
Per Family Unit	**None**		
OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR			
Per Covered Person	**Integrated Medical/ Prescription Drug OOP Maximum**		
Per Family Unit	**Integrated Medical/ Prescription Drug OOP Maximum**		
The maximum Out-of-Pocket for Prescription Drugs is combined with the medical Out-of-Pocket maximum amount. Charges for non-covered drugs and increased payments to cover the difference between the cost of generic and brand name drugs cannot be applied towards the maximum Out-of-Pocket amount.			
	PARTICIPATING PHARMACIES	**NON-PARTICIPATING PHARMACIES**	**COMMENTS**
Participating Retail Pharmacy (Up to 30-day supply) – For short-term medications			
Preventive Drugs	$0	**Prescriptions are only covered at participating pharmacies.**	**As classified by Health and Human Services (HHS)**
Generic Drugs	20% Copay		
Formulary Brand Drugs	20% Copay		
Non-Formulary Brand Drugs	20% Copay		
Prior authorization may be required if cost of medication exceeds $1,500.			
Ask your doctor or other prescriber if there is a generic available, as these generally cost less. If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the preferred drug list, which can be found on Caremark.com or under Member Documents on the Member Benefits portal via www.anchorbenefit.com. You will pay the most for medications not on the preferred drug list. **Note:** When a generic is available, but the pharmacy dispenses the brand name medication for any reason other than the doctor or other prescriber indicates "Dispense as Written", you will pay the difference between the brand name medication and the generic plus the brand co-payment, if applicable.			
Mail Order Pharmacy (Up to 90-day supply) – For long-term maintenance medications			
Generic Drugs	20% Copay	**Not Covered**	
Formulary Brand Drugs	20% Copay		
Non-Formulary Brand Drugs	20% Copay		
Prior authorization may be required if cost of medication exceeds $1,500.			

CITY OF SEBRING BASE HDHP PLAN
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DENTAL BENEFIT SCHEDULE
Optional Ancillary Benefit

<table>
<tr><td colspan="3">**There is no network associated with this plan, which means services may be rendered from any licensed dentist of your choice. ** Dental claims are paid in accordance with usual and customary rates. If course of treatment is to exceed $300, predetermination is requested.</td></tr>
<tr><td colspan="3">ANNUAL BENEFIT MAXIMUM AMOUNT, PER CALENDAR YEAR</td></tr>
<tr><td>Per Covered Person</td><td>$1,000</td><td></td></tr>
<tr><td colspan="3">ANNUAL DEDUCTIBLE AMOUNT, PER CALENDAR YEAR</td></tr>
<tr><td>Per Covered Person</td><td>$50</td><td></td></tr>
<tr><td>Per Family Unit</td><td>$100</td><td></td></tr>
<tr><td colspan="3">The Deductible does not apply to Preventive services.</td></tr>
<tr><td colspan="3">COVERED DENTAL SERVICES</td></tr>
<tr><td>Class I: Diagnostic/Preventive Services</td><td>100% Deductible Waived</td><td>Frequency and limitations apply below.</td></tr>
<tr><td colspan="3">

Two evaluations per Calendar year
Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar year
One topical fluoride per Calendar year up to age 19
Bitewing X-rays, once every 2 Calendar years
Periapical X-rays
One diagnostic X-ray, full or panoramic, once every 5 Calendar years
Emergency palliative treatment for pain
Space maintainers to preserve space between teeth for premature loss of a primary tooth. Limited to dependent children up to age 19
Sealants are not covered

</td></tr>
<tr><td>Class II: Basic Services</td><td>80% after Deductible</td><td></td></tr>
<tr><td colspan="3">

Dental X-rays not covered under Class I services
Amalgam and composite fillings other than gold
Antibiotic injections administered by a Dentist
Endodontic treatment of disease of the tooth, pulp, root and related tissue. (root canal)
Periodontics (such as periodontal cleanings, root scaling and planing)
Oral Surgery; including postoperative care for:

Removal of teeth, including impacted teeth
Extraction of tooth root in preparation for dentures
Excision of tumor or cyst and incision and drainage of an abscess or cyst.
Some limits may apply. Refer to plan document for details.

Simple extraction of teeth

</td></tr>
<tr><td>Class III: Major Services</td><td>50% after Deductible</td><td></td></tr>
<tr><td colspan="3">

Crown build-up
Installation/Repair of Crowns (Crowns excluded if it can be restored by other means)
Prosthetic services, limited to:

Initial placement of dentures or fixed bridgework.
Replacement of dentures or fixed bridgework

Recementing Bridges, inlays, onlays and crowns (Crowns excluded if it can be restored by other means)
Repair of dentures or fixed bridgework (Limits may apply. Refer to plan document for details)
Restoration services, limited to:

Gold inlays and onlays and foil fillings for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling. (Limits may apply. Refer to plan document for details)

</td></tr>
<tr><td>Class IV: Orthodontic</td><td>50% after Deductible</td><td>Limited to $1,000 Lifetime Max</td></tr>
<tr><td colspan="3">Additional information on dental care can be found in the Dental Benefits section of the Plan document.</td></tr>
</table>

EMPLOYEES ARE ENCOURAGED TO OBTAIN A PRE-DETERMINATION (EXCEPT FOR EMEREGENCY SITUATIONS) FOR TREATMENT EXPECTED TO EXCEED $300.

CITY OF SEBRING BASE HDHP PLAN
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VISION CARE BENEFIT SCHEDULE
Optional Ancillary Benefit

**There is no network associated with this plan, which means services may be rendered from any licensed optometrist of your choice. ** Vision claims are paid in accordance with usual and customary rates.	
ANNUAL BENEFIT MAXIMUM AMOUNT, PER CALENDAR YEAR	
Eye Exam (includes Contact lens exam)	Covered up to $50 per Covered Person
One routine eye exam per covered person, per calendar year	
Other Vision Care Expenses	Payable at 50% up to maximum of $250
• Frames • Lens Options (single, bifocal, trifocal) • Contact lenses (conventional/disposable) • Orthoptics are not covered (eye muscle exercises) Prescription Sunglasses or Prescription Safety goggles are covered under this benefit. **Additional information on Vision Care can be found in the Vision Care Benefits section of the Plan document.**	

CITY OF SEBRING PREMIUM PLAN
SCHEDULE OF MEDICAL BENEFITS
EFFECTIVE JANUARY 1, 2021

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Verification of Eligibility Call 1 (800) 845-7629 to verify eligibility for Plan benefits **before** the charge is incurred.

TIME LIMIT TO FILE A CLAIM: REQUESTS FOR PAYMENT OR REIMBURSEMENT MADE BY A COVERED PERSON OR HEALTHCARE PROVIDER MUST BE RECEIVED BY THE PLAN SUPERVISOR WITHIN 365 DAYS FROM THE DATE OF SERVICE TO BE CONSIDERED TIMELY FILED. PLEASE MAKE YOUR PROVIDER AWARE OF THE TIMELY FILING LIMIT.

The Schedule of Benefits highlights and summarizes some provisions of the Plan that describe amounts you will need to pay as cost-sharing amounts, and some things that may limit the amount of benefits you can receive under the Plan. This section of the document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. Refer to the covered Medical Benefits and Plan Exclusions sections of the summary plan description for more details. The meanings of these capitalized terms are in the Defined Terms section of this document.

This Plan does not pay all medical expenses. It pays certain expenses under certain circumstances. For an expense to be "covered" under this Plan, a number of requirements must be met, including –

- The person receiving the service giving rise to the expense must be a covered individual;
- The service giving rise to the expense must be a covered service;
- The expense for the covered service must meet the requirements of a covered charge; and
- The covered individual must pay any applicable cost-sharing amounts.

REQUIRED PRECERTIFICATION (PRIOR AUTHORIZATION)

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The covered charges for certain covered services may be reduced or entirely excluded if the covered individual does not receive pre-certification (pre-treatment authorization) for the specific covered service. Pre-certification is always the covered individual's responsibility. Any amounts for which a covered individual is financially responsible due to a failure to follow the pre-certification procedures are considered outside of the scope of the Plan, and are not counted to the satisfaction of the Deductible or the Out-of-Pocket Maximum.

Generally, providers notify the plan before they provide these services to you. However, there are some benefits for which you are responsible for notifying the plan. This Plan has contracted with a Utilization Review Program and requires pre-certification on ALL Hospital confinements, as well as other Plan requirements as outlined in the Schedule of Benefits.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced. Before hospital admission or surgery (outside the physician's office) or for other services as specified in your plan your physician must call for pre-treatment authorization (pre-certification). Note, that if a Covered Person received Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency.

Please call Anchor Benefit Consulting, Inc. for pre-certification at 1-800-845-7629 or 407-667-8766.

Emergency hospital admissions must be reported within 72 hours or by the next regular working day following admission. The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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Services for which you must pre-certify are identified below and in the Schedule of Benefits table.

Inpatient Pre-Certification:
Inpatient Acute Care (Services rendered in a hospital setting not included in any other inpatient pre-cert category.)
Detox
Long term acute care
Rehabilitation
Routine and High Risk Maternity
(routine only if inpatient stay exceeds federal requirements)
Skilled Nursing Facility
Inpatient Mental Health & Substance Abuse
(Hospital/Residential/partial hospitalization)

Outpatient Pre-Certification:
Cochlear Implants (osseointegrated, cochlear or auditory brain stem implant)
Dialysis
Durable Medical Equipment
Experimental/Investigational/Unproven Procedures
Home Health Care
Home Infusion Therapy (immunotherapy, continuous medications, hydration, total parenteral nutrition, pain management)
Injectable medications (immune globulin, drugs for factor deficiencies, interferon, Rituxan, some chemotherapeutic agents)
Orthotics and Prosthetics
Outpatient Procedures (not otherwise categorized, such as facial reconstruction, varicose vein treatment, blepharoplasty, rhinoplasty and breast reconstruction/reduction**)** Surgeries and procedures that may not be medically necessary.
Sleep Management Program (obstructive sleep apnea, diagnostic or therapeutic sleep studies)
Speech Therapy
Spinal Procedures (Allograft/osteopromotive material for spine surgery, osteotomy, percutaneous vertebroplasty, arthrodesis, laminectomy, vertebral corpectomy, destruction by neurolytic agent, laminotomy, facet joint nerve destruction, spinal cord decompression)
Therapeutic Radiology (Brachytherapy, proton beam therapy, radiotherapy)
Transplants (Adult or pediatric, living or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants; preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants; transplant-related travel and lodging)
Unlisted procedures (vascular surgery, miscellaneous DME, unclassified drugs/biologics including antineoplastics, lower extremity prosthesis)

******Observation level of care for stays less than 24 hours are not reviewed for medical necessity. Observation level of care can be approved for services over 24 hours, not to exceed 48 hours. Any stay lasting over 48 hours is considered inpatient acute care.

HEALTH CARE PROVIDERS

Under this Plan, covered individuals may receive different levels of coverage depending on where covered services are received. Generally, when covered services are received from an In-Network provider, the covered individual will receive the highest level of coverage (meaning the covered individual generally will be responsible for less of the cost). When covered services are received from an Out-of-Network provider, the covered individual generally will receive a lower level of coverage and be responsible for any amounts charged by the Out-of-Network provider above Usual and Customary Rates.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

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If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

To receive In-Network benefits, a Covered Person must receive treatment from a contracted health care provider. The Employer has selected the Cigna PPO network to offer health care services through specific Physicians, Hospitals and various other service providers.

IT IS THE RESPONSIBILITY OF THE COVERED PERSON TO CHOOSE PROVIDERS WITHIN THE NETWORK FOR MAXIMUM BENEFIT COVERAGE.

The Plan is a plan which contains a Preferred Provider Organization (PPO).

Medical PPO name:	**Cigna PPO**
Address:	P.O. Box 188061 Chattanooga, TN 37422-8061
Website:	www.Cigna.com
Payor ID:	**62308**

To confirm if a provider is In-Network, review the current provider directory, which can be found online when you register with www.myCigna.com. If you do not wish to register, you can also search for a provider by going to www.Cigna.com and clicking on “Find a Doctor, Dentist or Facility” at the top of the page and then selecting “Employer or school” under “How are you Covered?”. You will then be directed to the directory search page. Enter your address or zip code then choose your search method, Doctor by Type, Doctor by Name or Health Facilities. Thereafter, you may be asked to login/register or continue as a guest. If you continue as a guest, be sure to select your plan’s network by clicking on Continue. A list of networks will appear, select “PPO, Choice Fund PPO”. A list of your search criteria will appear. You can print the list by scrolling to the end of the listing and clicking on the “Print/Save PDF”. It is important you select the Plan’s network to ensure you are viewing the correct listing.

Under the following circumstances, the higher In-Network payment will be made for certain Out-of-Network services:

If a Covered Person has no choice of In-Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a Out-of-Network Provider at an In-Network facility.

USUAL AND CUSTOMARY RATES

The Plan pays benefits based on covered charges, not actual charges. Covered charges cannot exceed the Usual and Customary Rates (UCR) of a covered service, as determined by the Plan. If an Out-of-Network provider charges more than the Usual and Customary Rates (as determined by the Plan), the covered individual is responsible for the amount in excess of the Usual and Customary Rates. This excess amount is considered outside the scope of the Plan and is not counted toward the satisfaction of the Deductible nor the Out-of-Pocket Maximum. The claims for the dental plan are paid according to UCR.

Enrolling for coverage under this Plan does not automatically guarantee services by a participating Provider. The list of participating Providers is subject to change. When a Provider no longer has a contract with a network, you must choose another physician among the remaining participating Providers to receive maximum benefit coverage.

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	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS	COMMENTS
Lifetime Dollar Maximum Amount: Unlimited for essential health benefits.			
ANNUAL DEDUCTIBLE AMOUNT, PER CALENDAR YEAR			
Individual	$1,000	$3,000	
Per Family Unit	$2,000	$6,000	No one person will pay more than his/her individual Deductible amount.
The Deductible is waived for In-Network Preventive Care, preventive drugs, office visits, diagnostic testing, advanced imaging, newborn care and other services as specified. Copayments do not apply to the Deductible.			
Coinsurance	20%	50%	Paid by Covered Person after satisfaction of Deductible, where applicable.
ANNUAL MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Individual	$6,000	$8,000	
Per Family Unit	$12,000	$15,000	No one person will pay more than his/her individual Out-of-Pocket maximum amount.
The maximum Out-of-Pocket amount includes the Deductible, Copayments (health care service and outpatient prescription), and Coinsurance. After the maximum Out-of-Pocket amount has been satisfied, the Plan will pay 100% of eligible expenses up to the allowable charge for the remainder of the Calendar year.			
COVERED SERVICES AND BENEFIT AMOUNT			
PREVENTIVE CARE SERVICES			
Routine Wellness Services for Adults	Plan pays 100%	Plan pays 50% after Deductible	Limited to one routine physical exam/calendar year. Age and frequency limits may apply.
Standard Preventive Care shall be provided as required by applicable law if provided by a Network provider. Standard Preventive care for adults includes services with an “A” or “B” rating from the United States Preventive Services Task Force which includes physician office services, scopic procedures, lab, X-ray, or recommended screenings, routine physical exam, immunizations, and contraceptives. These services are based on your age, gender and other health factors. This is not an all-inclusive list. Mammograms must be over age 40 unless Medically Necessary and routine colonoscopies age 50+ unless Medically Necessary.			
Routine Wellness Services for Children	Plan pays 100%	Plan pays 50% after Deductible	Limited to one routine physical exam/calendar year. Age and frequency limits may apply.
Standard Preventive Care shall be provided as required by applicable law if provided by a Network provider. Standard Preventive care for children includes services with an “A” or “B” rating from the United States Preventive Services Task Force which includes physician office services, lab, X-ray, hearing tests, vision tests, or recommended screenings, routine physical exam and immunizations up to age 18. These services are based on age, gender and other health factors. This is not an all-inclusive list.			
PHYSICIAN SERVICES			
Physician Office Visit	$40 Co-pay/visit	Plan pays 50% after Deductible	Includes services billed from a Physician office setting.
Specialist Office Visit	$75 Co-pay/visit	Plan pays 50% after Deductible	Includes services billed from a Physician office setting.
Virtual Visits	$15 Co-pay/visit	Not Covered	Includes services billed from a Physician office setting.
Office Surgery	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Diagnostic Testing	Plan pays 80% Deductible Waived	Plan pays 50% after Deductible	Includes X-rays and lab testing in a Physician’s office setting.

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	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS	COMMENTS
EMERGENCY AND URGENT CARE SERVICES			
Urgent Care Center	$40 Co-pay/visit	Plan pays 50% after Deductible	
Ambulance Service	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible	Limited to ground/air transport to nearest facility
Emergency Room Visit/Includes Physician Care	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible	Emergency only
Emergency hospital admissions must be reported to Anchor Benefit Consulting (800-845-7629) within 72 hours or by the next regular working day following admission even if the patient is discharged within 72 hours of the admission.			
Non-Emergency Room Visit/Includes Physician Care	Plan pays 50% after Deductible	Plan pays 40% after Deductible	Applies to non-emergent use of ER
DIAGNOSTIC SERVICES			
Diagnostic Testing	Plan pays 80% Deductible Waived	Plan pays 50% after Deductible	Applies to independent facility and Hospital facility.
Advanced Imaging	Plan pays 80% Deductible Waived	Plan pays 50% after Deductible	Prior authorization required Applies to office, independent facility and Hospital facility.
Advanced Imaging includes: CT, MRI, MRA, PET, and nuclear scans. Myocardial perfusion imaging, cardiac blood pool imaging and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms.			
HOSPITAL SERVICES			
Pre-Admission Testing	Plan pays 100%	Plan pays 50% after Deductible	
Inpatient Facility (Hospital room)	$500 Copay/admit then Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
**Observation level of care for stays less than 24 hours are not reviewed for medical necessity. Observation level of care can be approved for services over 24 hours, not to exceed 48 hours. Any stay lasting over 48 hours is considered inpatient acute care.			
Intensive Care Unit	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
Outpatient Surgery	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
Physician/Surgeon Fees	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Skilled Nursing Facility	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required Limited to 60 days/calendar year
Organ Transplants	$500 Copay/admit then Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
Must be medically necessary and non-experimental. The Cigna LifeSource Transplant Network must be used to gain access to the network of participating organ and tissue transplant centers. For more information, visit: www.cignalifesource.com.			
REHABILITATION THERAPY SERVICES			
Chiropractic Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Limited to 24 visits/calendar year.
Habilitation Services	Not Covered	Not Covered	
Physical Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Occupational Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Speech Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	

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	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS	COMMENTS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Inpatient Facility	$500 Copay/admit then Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Residential Treatment	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Partial Hospitalization	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Outpatient Office Visit	$75 Co-pay/visit	Plan pays 50% after Deductible	
MATERNITY AND ROUTINE NURSERY CARE SERVICES			
Pregnancy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required. See note below.
The attending Physician does not have to obtain prior authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. **Prior Authorization Required for Routine and High-Risk Maternity (routine only if inpatient stay exceeds federal requirements).**			
Birthing Center	Plan pays 80%, Deductible Waived	Plan pays 50% after Deductible	
Newborn Nursery/Physician Care	Plan pays 80%, Deductible Waived	Plan pays 50% after Deductible	Paid under newborn's plan
OTHER COVERED MEDICAL SERVICES			
Ambulatory Surgical Center	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior authorization required
Bariatric Surgery	Not Covered	Not Covered	
Bereavement Counseling	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Chemotherapy/Radiation	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Wig after Chemotherapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Covers charges associated w/initial purchase.
Cochlear Implants	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Dialysis	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Durable Medical Equipment & Supplies	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Hearing Aids/Exams	Not Covered	Not Covered	
Home Health Care Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required Limited to 40 visits/Calendar Year
Hospice Care	Plan pays 80% after Deductible	Plan pays 50% after Deductible	
Infertility	Not Covered	Not Covered	
Infusion Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Injectable Medications	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required
Certain injectables may require prior authorization such as immune globulin, drugs for factor deficiencies, interferon, Rituxan, and some chemotherapeutic agents.			
Jaw Joint/TMJ	Plan pays 80% after Deductible	Plan pays 50% after Deductible	

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	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS	COMMENTS
Oral Surgery	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Limited to Injury to or care of mouth, sound natural teeth and gums
Orthotics/Prosthetics	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required Ortho limited to one pair of shoes/Calendar Year
Sleep Management	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization Required. Includes obstructive sleep apnea, diagnostic or therapeutic sleep studies.
All Other Covered Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible	Prior Authorization may be required for unlisted procedures.

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PRESCRIPTION DRUG BENEFIT

Following is a brief summary of your prescription drug benefits. Co-payment and/or Coinsurance is determined by the tier to which CVS Caremark (drug formulary) has assigned the prescription drug. To view medicine history, track your spending, compare medicine costs and find lower-priced options, check for possible drug interactions, track your refills, and search for participating pharmacies, visit www.caremark.com or call Customer Care at 1-866-475-0056.

Note, products covered by the prescription drug benefit plan may change from time to time in accordance with CVS Caremark prescription management guidelines. Call CVS Caremark to ensure your specific medication is covered under the Plan. You can access CVS Caremark's "Ask a Pharmacist" online tool at Caremark.com, email a pharmacist or view online frequently asked questions.

PRESCRIPTION DRUG DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	**NONE**	
Per Family Unit	**NONE**	
OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR		
Per Covered Person	**Integrated Medical/ Prescription Drug OOP Maximum**	
Per Family Unit	**Integrated Medical/ Prescription Drug OOP Maximum**	

The maximum Out-of-Pocket for Prescription Drugs is combined with the medical Out-of-Pocket maximum amount. Charges for non-covered drugs and increased payments to cover the difference between the cost of generic and brand name drugs cannot be applied towards the maximum Out-of-Pocket amount.

	PARTICIPATING PHARMACIES	**NON-PARTICIPATING PHARMACIES**	**COMMENTS**
Participating Retail Pharmacy (Up to 30-day supply) – For short-term medications			
Preventive Drugs	$0	**Prescriptions are only covered at participating pharmacies.**	**As classified by Health and Human Services (HHS)**
Generic Drugs	20% Copay		
Formulary Brand Drugs	20% Copay		
Non-Formulary Brand Drugs	20% Copay		

Prior authorization may be required if cost of medication exceeds $1,500.

Ask your doctor or other prescriber if there is a generic available, as these generally cost less. If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the preferred drug list, which can be found on Caremark.com or under Member Documents on the Member Benefits portal via www.anchorbenefit.com. You will pay the most for medications not on the preferred drug list.

Note: When a generic is available, but the pharmacy dispenses the brand name medication for any reason other than the doctor or other prescriber indicates "Dispense as Written", you will pay the difference between the brand name medication and the generic plus the brand co-payment, if applicable.

Mail Order Pharmacy (Up to 90-day supply) – For long-term maintenance medications			
Generic Drugs	20% Copay	**Not Covered**	
Formulary Brand Drugs	20% Copay		
Non-Formulary Brand Drugs	20% Copay		

Prior authorization may be required if cost of medication exceeds $1,500.

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DENTAL BENEFIT SCHEDULE
Optional Ancillary Benefit

There is no network associated with this plan, which means services may be rendered from any licensed dentist of your choice. ** Dental claims are paid in accordance with usual and customary rates. If course of treatment is to exceed $300, predetermination is requested.		
ANNUAL BENEFIT MAXIMUM AMOUNT, PER CALENDAR YEAR		
Per Covered Person	**$1,000**	
ANNUAL DEDUCTIBLE AMOUNT, PER CALENDAR YEAR		
Per Covered Person	**$50**	
Per Family Unit	**$100**	
The Deductible does not apply to Preventive services.		
COVERED DENTAL SERVICES		
Class I: Diagnostic/Preventive Services	**100% Deductible Waived**	Frequency and limitations apply below.
• Two evaluations per Calendar year • Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar year • One topical fluoride per Calendar year up to age 19 • Bitewing X-rays, once every 2 Calendar years • Periapical X-rays • One diagnostic X-ray, full or panoramic, once every 5 Calendar years • Emergency palliative treatment for pain • Space maintainers to preserve space between teeth for premature loss of a primary tooth. Limited to dependent children up to age 19 • Sealants are not covered		
Class II: Basic Services	**80% after Deductible**	

• Dental X-rays not covered under Class I services
• Amalgam and composite fillings other than gold
• Antibiotic injections administered by a Dentist
• Endodontic treatment of disease of the tooth, pulp, root and related tissue. (root canal)
• Periodontics (such as periodontal cleanings, root scaling and planing)
• Oral Surgery; including postoperative care for:
  o Removal of teeth, including impacted teeth
  o Extraction of tooth root in preparation for dentures
  o Excision of tumor or cyst and incision and drainage of an abscess or cyst.
  o Some limits may apply. Refer to plan document for details.
• Simple extraction of teeth		

Class III: Major Services	**50% after Deductible**	

• Crown build-up
• Installation/Repair of Crowns (Crowns excluded if it can be restored by other means)
• Prosthetic services, limited to:
  o Initial placement of dentures or fixed bridgework.
  o Replacement of dentures or fixed bridgework
• Recementing Bridges, inlays, onlays and crowns (Crowns excluded if it can be restored by other means)
• Repair of dentures or fixed bridgework (Limits may apply. Refer to plan document for details)
• Restoration services, limited to:
  o Gold inlays and onlays and foil fillings for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling. (Limits may apply. Refer to plan document for details)		

Class IV: Orthodontic	**50% after Deductible**	**Limited to $1,000 Lifetime Max**
Additional information on dental care can be found in the Dental Benefits section of the Plan document.		

EMPLOYEES ARE ENCOURAGED TO OBTAIN A PRE-DETERMINATION (EXCEPT FOR EMEREGENCY SITUATIONS) FOR TREATMENT EXPECTED TO EXCEED $300.

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VISION CARE BENEFIT SCHEDULE
Optional Ancillary Benefit

There is no network associated with this plan, which means services may be rendered from any licensed optometrist of your choice. ** Vision claims are paid in accordance with usual and customary rates.	
ANNUAL BENEFIT MAXIMUM AMOUNT, PER CALENDAR YEAR	
Eye Exam (includes Contact lens exam)	Covered up to $50 per Covered Person
One routine eye exam per covered person, per calendar year	
Other Vision Care Expenses	Payable at 50% up to maximum of $250

- Frames
- Lens Options (single, bifocal, trifocal)
- Contact lenses (conventional/disposable)
- Orthoptics are not covered (eye muscle exercises)

Prescription Sunglasses or Prescription Safety goggles are covered under this benefit.

Additional information on Vision Care can be found in the Vision Care Benefits section of the Plan document.