MEDICAL SCHEDULE OF BENEFITS – VALUE GOLD BANNER 2023-2024

VALUE GOLD BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR DEDUCTIBLE			
Single	$600	$750	$3,000
Family	$1,200	$1,500	$9,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card)			
Single	$4,000	$5,000	Not Applicable
Family	$8,000	$10,000	Not Applicable
MEDICAL BENEFITS			
Allergy Serum & Injections			
Injections (If no office visit charge)	100% after $5 Copay per visit; Deductible waived	100% after $5 Copay per visit; Deductible waived	50% after Deductible
Serum	100% after $36 Copay per visit; Deductible waived	100% after $45 Copay per visit; Deductible waived	50% after Deductible
Ambulance Services			
Ground Ambulance Services	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Air Ambulance Services	$200 Copay per trip, then 75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Ambulatory Surgical Center	75% after Deductible	75% after Deductible	50% after Deductible
Anesthesiologist	75% after Deductible	75% after Deductible	50% after Deductible
Anti-Embolism Garments	$40 Copay per pair, then 75%; Deductible waived	$50 Copay per pair, then 75%; Deductible waived	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs		

VALUE GOLD BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Cardiac Rehab (Outpatient)	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Chemotherapy (Outpatient – includes all related charges)	75% after Deductible	75% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 visits		
Diabetic Supplies	100% after $30 Copay per item; Deductible waived	100% after $30 Copay per item; Deductible waived	50% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)			
Any Single Service Costing Less Than $500	75% after Deductible	75% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	75% after Deductible	75% after Deductible	50% after Deductible
Freestanding Laboratory	75%; Deductible waived	75%; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	75% after Deductible	75% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	75% after Deductible	75% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	75% after Deductible	75% after Deductible	50% after Deductible
Emergency Services			
Emergency Medical Condition			
Facility Charges	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Professional Fees and Ancillary Charges	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Non-Emergency Medical Condition			
Facility Charges	75% after Deductible	75% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	75% after Deductible	75% after Deductible	50% after Deductible

VALUE GOLD BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Empower Health (TIN: 36-4836722)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: Empower Health wellness program is a voluntary wellness program available to the Employee only, Dependent Spouses and Children are not eligible. If you elect to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related choices. You will also be asked to complete a biometric screening, which will include a blood pressure reading and blood test. For more information regarding this program you may call Empower Health at (866) 367-6974.			
Foot Orthotics	$40 Copay per orthotic, then 75%; Deductible waived	$50 Copay per orthotic, then 75%; Deductible waived	$50 Copay per orthotic, then 50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months		
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	75% after Deductible	75% after Deductible	50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period		
Hemodialysis (Outpatient)	75% after Deductible	75% after Deductible	50% after Deductible
Hinge Health Program (TIN 81-1884841)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: Please refer to the Hinge Health Program section of this Plan for a more detailed description of this benefit. If treatment is received from providers outside of the Hinge Health Network, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.			
Home Health Care	75% after Deductible	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*		
*Home health care supplies are not subject to the Calendar Year Maximum.			
Hospice Care			
Inpatient	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	75% after Deductible	75% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	75% after Deductible	75% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.			

VALUE GOLD BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Infusion Therapy in Facility or Physician's Office	75% after Deductible	75% after Deductible	50% after Deductible
Maternity (Non-Facility Charges)*			
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	75% after Deductible	75% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.			
Medical and Surgical Supplies	75% after Deductible	75% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders			
Inpatient			
Facility Charge	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Fees	75% after Deductible	75% after Deductible	50% after Deductible
Outpatient Facility	75% after Deductible	75% after Deductible	50% after Deductible
Office Visits	100% after $28 Copay; Deductible waived	100% after $35 Copay; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.			
Morbid Obesity (Surgical Treatment Only)			
Facility (Inpatient and outpatient)	$200 Copay, then 75%; Deductible waived	$250 Copay, then 75%; Deductible waived	50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure		
Nutritional Food Supplements	50% after Deductible	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		

VALUE GOLD BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Pain Management	Paid based on place of service	Paid based on place of service	Paid based on place of service
Calendar Year Maximum Benefit	Not Applicable	Not Applicable	4 visits
Physical Therapy (Outpatient)	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Physician's Services			
Inpatient/Outpatient Services			
Primary Care Physician	75% after Deductible	75% after Deductible	50% after Deductible
Specialist	75% after Deductible	75% after Deductible	50% after Deductible
Office Visits			
Primary Care Physician	100% after $28 Copay*; Deductible waived	100% after $35 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $36 Copay*; Deductible waived	100% after $45 Copay*; Deductible waived	50% after Deductible
Physician Office Surgery			
Primary Care Physician	Under $1,000 - 100% after $28 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	Under $1,000 - 100% after $35 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	50% after Deductible
Specialist	Under $1,000 - 100% after $36 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	Under $1,000 - 100% after $45 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			

VALUE GOLD BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care			
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	100%; Deductible waived	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% of the first $300 per Calendar Year, then 10%; Deductible waived	100% of the first $300 per Calendar Year, then 10%; Deductible waived	Not Covered
Flu, Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	100% after $28 Copay per exam; Deductible waived	100% after $35 Copay per exam; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam		
NOTE: Preventive prenatal and breastfeeding support are paid under the Maternity Benefit. Please see Maternity listed above for additional details.			
Prosthetics (other than bras)	75% after Deductible	75% after Deductible	50% after Deductible
Prosthetic Bras	75% after Deductible	75% after Deductible	75% after Deductible
Calendar Year Maximum Benefit	2 bras		
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient - includes all related charges)	75% after Deductible	75% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days		
Skilled Nursing Facility	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days		
SkinIO Provider (Skin Cancer Screenings)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: SkinIO is technology-based skin cancer screenings – providing access for early detection of skin cancer via photo-taking; remote dermatologist review; mole mapping; and change tracking and outlier detection for earlier detection for persons age 18 and over. TIN: 82-2035738			

VALUE GOLD BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Speech Therapy (Outpatient)	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Surgery (Inpatient)			
Facility	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include Surgery in the Physician's office)			
Facility	75% after Deductible	75% after Deductible	50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Teladoc Network Providers	Not Applicable	100%; Deductible waived	Not Applicable
Telemedicine			
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Temporomandibular Joint Dysfunction (TMJ)	$40 Copay per occurrence, then 75%; Deductible waived	$50 Copay per occurrence, then 75%; Deductible waived	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000		

VALUE GOLD BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants			
Facility Charges	$200 Copay per admission, then 75%; Deductible waived (Aetna IOE Program)*	$250 Copay per admission, then 75%; Deductible waived (Aetna IOE Program)*	Not Covered
Professional Fees	75% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	75% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.			
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.			
Urgent Care Facility	$46 Copay* per visit, then 100%; Deductible waived	$55 Copay* per visit, then 100%; Deductible waived	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			
Wig (see Eligible Medical Expenses)	$40 Copay per wig, then 75%; Deductible waived	$50 Copay per wig, then 75%; Deductible waived	$50 Copay per wig, then 75%; Deductible waived
Maximum Benefit per 24 Month Period	1 wig		
All Other Eligible Medical Expenses	$40 Copay*, then 75%; Deductible waived	$50 Copay*, then 75%; Deductible waived	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.			

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – VALUE GOLD BANNER 2023-2024

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical Out-of-Pocket) Single Family	 $5,000 $10,000
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	40% Copay ($40 minimum, $110 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications Generic Brand Diabetic Supplies Generic Brand	 $5 Copay $15 Copay $5 Copay $15 Copay
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through the PrudentRx Copay Program	20% Copay ($100 minimum, $150 maximum)
Enrolled and Available in the PrudentRx Copay Program	$0 Copay
Not Enrolled and Available in the PrudentRx Copay Program	30% Copay
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program.	
CVS Maintenance Choice – Allow Opt-Out: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Diabetic Insulin Medications	
Generic	$10 Copay
Brand	$30 Copay
Diabetic Supplies	
Generic	$10 Copay
Brand	$30 Copay
Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications	
Generic	$10 Copay
Brand	$30 Copay
Diabetic Supplies	
Generic	$10 Copay
Brand	$30 Copay

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense as Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS Maintenance Choice Mandatory – Allow Opt Out
The Plan allows for 2 30-day fills of maintenance drugs at any Participating retail pharmacy. After 2 fills, a 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy or through the mail order program unless you call the Prescription Drug Program Administrator and opt out. If you opt out, you may continue to purchase a 30-day supply of maintenance drugs, however, you will not benefit from the savings of a 90-day supply. For additional information, please contact the Prescription Drug Card Program Administrator.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Advanced Control Specialty Formulary
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

PrudentRx Copay Program for Specialty Medications
Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Copay Program will assist individuals in obtaining copay assistance from drug manufacturers to reduce an individual's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible persons will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications, in that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copays for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count towards your Out-of-Pocket Maximum. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.