Albion College, G-6000

Benefit Description	Plan 2 PPO Plan		Plan 2 HDHP/HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit Year	January 1 through December 31		January 1 through December 31	
Comprehensive Medical Benefit				
Deductible per Benefit Year	$1,500/person $3,000/family	$3,000/person $6,000/family	$3,500person $7,000/family	$7,000/person $14,000/family
General Benefit Percentage	80% after deductible (20% coinsurance)	60% after deductible (40% coinsurance)	80% after deductible (20% coinsurance)	60% after deductible (40% coinsurance)
Coinsurance Maximum Out-of-Pocket per Benefit Year	$4,850/person $9,750/family	$9,750/person $19,000/family	Not applicable to this plan option; refer to the Total Maximum Out-of-Pocket amounts below	Not applicable to this plan option; refer to the Total Maximum Out-of-Pocket amounts below
Total Maximum Out-of-Pocket per Benefit Year	$6,350/person $12,750/family	$12,750/person $25,500/family	$6,000/person $12,000/family	$12,000/person $24,000/family
	Special Notes about the Comprehensive Medical Benefit: 1. An individual within a family has to meet only the per-person deductible specified above before the Plan will begin paying benefits. Additionally, an individual within a family has to meet only the per-person Coinsurance Maximum Out-of-Pocket before the Plan's general benefit percentage will increase to 100% for the remainder of the Benefit Year for the applicable benefit tier or the per-person Total Maximum Out-of-Pocket for In-Network charges before medical and prescription drug co-payments will no longer be charged for the remainder of the Benefit Year. 2. The deductible and Coinsurance Maximum Out-of-Pocket do not include co-payments of any type or medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the usual and customary charge allowed by the Plan, exceed the limits of the Plan, or are Amounts applied toward the deductible or Coinsurance Maximum Out-of-Pocket for in-network services will also accrue toward the deductible or Coinsurance Maximum Out-of-Pocket for out-of-network services, and vice versa. In no event shall the deductible or Coinsurance Maximum Out-of-Pocket for all in-network and out-of-network services combined exceed the out-of-network amounts shown above. 3. The Total Maximum Out-of-Pocket amounts include deductibles, coinsurance, medical co-payments, and prescription drug co-payments. These amounts do not include medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the usual and customary charge, exceed limits of the Plan, or are otherwise excluded. Amounts applied toward the Total Maximum Out-of-Pocket for in-network services will also accrue toward the Total Maximum Out-of-Pocket for out-of-network services, and vice versa. In no event shall the Total Maximum Out-of-Pocket for all in-network and out-of-network services combined exceed the out-of-network amounts shown above.		**Special Notes about the Comprehensive Medical Benefit:** 1. An individual within a family has to meet only the per-person deductible before the Plan will begin paying benefits. Additionally, an individual within a family has to meet only the per-person Total Maximum Out-of-Pocket before the Plan's general benefit percentage will increase to 100% for the applicable benefit tier. Medical and prescription drug co-payments will no longer be charged for the remainder of the Benefit Year after the applicable In-Network Total Maximum Out-of-Pocket is satisfied. 2. The Total Maximum Out-of-Pocket amounts include deductibles, coinsurance, medical co-payments, and prescription drug co-payments. These amounts do not include medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the usual and customary charge, exceed limits of the Plan, or are otherwise excluded. Amounts applied toward the deductible or Total Maximum Out-of-Pocket for in-network services will also accrue toward the deductible or Total Maximum Out-of-Pocket for out-of-network services, and vice versa. In no event shall the deductible or Total Maximum Out-of-Pocket for all in-network and out-of-network services combined exceed the out-of-network amounts shown above.	

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Benefit Description	Plan 2 PPO Plan		Plan 2 HDHP/HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Physician Services (Includes Office Visits, Telemedicine E-Visits, and Second Surgical Opinions) Physician's Fee for an Examination	*Telemedicine E-Visits:* $-0- co-payment per visit, then 100% (deductible waived) *Primary Care Provider Office Visits:* $25 co-payment per visit, then 100% (deductible waived) *Specialist Office Visits:* $35 co-payment per visit, then 100% (deductible waived)	*Telemedicine E-Visits:* 60% after deductible *Primary Care Provider Office Visits:* 60% after deductible *Specialist Office Visits:* 60% after deductible	*Telemedicine E-Visits:* 100% after deductible *Primary Care Provider Office Visits:* 80% after deductible *Specialist Office Visits:* 80% after deductible	*Telemedicine E-Visits:* 60% after deductible *Primary Care Provider Office Visits:* 60% after deductible *Specialist Office Visits:* 60% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered
Special Notes about the Outpatient Physician Visits Benefit: 1. The term "Primary Care Provider" means a physician, physician's assistant, nurse practitioner, or other eligible provider who provides Medical Care in primary care, family practice, general practice, outpatient or intensive outpatient behavioral care services, internal medicine, obstetrics and gynecology, or pediatrics. For the purposes of this benefit, the term "Medical Care" does not include any services otherwise addressed in this summary (e.g., chiropractic care). The term "Specialist" means a physician with advanced education and training in a recognized medical specialty who is not a Primary Care Provider as defined above. Specialists are often licensed or certified in their medical specialty. 2. For enrollees in the Plan 2 PPO Plan option only, eligible charges for outpatient allergy services, miscellaneous medical supplies, anesthesia, surgery, diagnostic X-rays, diagnostic lab tests, and infusion/injection therapy performed by an in-network provider and billed with a place of service code "11" (physician's office) shall be paid at 100% and all applicable deductible amounts shall be waived. The co-payment applicable to the physician's exam will still be assessed.				
Routine Preventive Care Physician's Fee for an Examination Routine X-Rays and Lab Tests Flu Shots and Other Routine Immunizations FDA-Approved Contraceptive Methods and Sterilization Procedures for Women with Reproductive Capacity Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived	60% after deductible	100%; deductible waived	60% after deductible
Special Notes about Routine Preventive Care: 1. Coinsurance or an office visit co-payment may be imposed on preventive care services if either the visit is billed separately from the preventive care service or the services are provided during an office visit whose primary purpose is not preventive care (and the services are not billed separately). 2. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; routine immunizations, including those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (see preventive care summary on the Claim Administrator's Website for a list of these immunizations); evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.				
Routine Immunizations Administered in a Pharmacy or at the Department of Community Health (Includes Injection Fee Charges)	100%; deductible waived	100%; deductible waived	100%; deductible waived	100%; deductible waived
Special Note about the Routine Immunizations Benefit: The covered person may have to initially pay for these charges in full and then submit the expense directly to the Claim Administrator for reimbursement.				

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Benefit Description	Plan 2 PPO Plan		Plan 2 HDHP/HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Urgent Care Center Visits Physician's Fee for an Examination	$35 co-payment per visit, then 100% (deductible waived)	60% after deductible	80% after deductible	60% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered
Emergency Room Treatment Physician's Fee for an Examination in the Emergency Room	$100 co-payment* per visit, then 100% (deductible waived) *will be waived if admitted	Paid as in-network	80% after deductible	Paid as in-network
All Other Charges Billed by the Hospital, Physician, or Any Other Provider in Connection with the Emergency Room Visit	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid as in-network	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid as in-network
Special Note about the Emergency Room Treatment Benefit: The Plan does not require certification for emergency services.				
Ambulance Transportation (Ground or Air)	80% after deductible	Paid as in-network	80% after deductible	Paid as in-network
Certification Requirement	Certification is required for all inpatient hospital admissions, observational stays at the hospital, select surgical procedures, and certain outpatient services listed at the end of this summary			
Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient Physician Services Hospital Visits, Surgical Procedures, and Anesthesiology	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Obesity Treatment	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Special Note about Obesity Surgical Treatment: The Plan will cover one surgery to treat obesity per covered person in a lifetime.				
Outpatient Services Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Diagnostic X-Rays and Lab Test Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
	Special Note about the Outpatient Services Benefit: Eligible charges for anesthesia, surgery, diagnostic X-rays, and diagnostic lab tests performed by an in-network provider and billed with a place of service code "11" (physician's office) shall be paid at 100% and all applicable deductible amounts shall be waived. Any co-payment applicable to the physician's exam will still be assessed.			

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Benefit Description	Plan 2 PPO Plan		Plan 2 HDHP/HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Allergy Services Injections, Serum, and Testing	80% after deductible	60% after deductible	80% after deductible	60% after deductible
	Special Note about the Allergy Services Benefit: Eligible charges for outpatient allergy services performed by an in-network provider and billed with a place of service code "11" (physician's office) shall be paid at 100% and all applicable deductible amounts shall be waived. Any co-payment applicable to a physician's exam will still be assessed.			
Outpatient Infusion/Injection Therapy	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Special Notes about the Outpatient Infusion/Injection Therapy Benefit: 1. The infusion or injection of medications that are self-administered or that are administered in most outpatient settings will generally be subject to the Plan's Certification Requirement (see above) if the per-dosage cost is $2,000 or more per 30-day supply. A covered person can call the Certification telephone number on the health plan identification card to determine if a prescribed medication is subject to the Plan's Certification Requirement. 2. For enrollees in the Plan 2 PPO Plan option only, eligible charges for infusion/injection therapy performed by an in-network provider and billed with a place of service code "11" (physician's office) shall be paid at 100% and all applicable deductible amounts shall be waived. Any co-payment applicable to the physician's exam will still be assessed.				
Chiropractic Care Spinal Manipulations, Therapy Treatments, and a Physician's Fee for an Initial or Periodic Evaluation	$35 co-payment per day, then 100% (deductible waived)	60% after deductible	80% after deductible	60% after deductible
Diagnostic Spinal X-Rays	80% after deductible	60% after deductible	80% after deductible	60% after deductible
24 Visits* Allowed per Covered Person per Benefit Year for All Chiropractic Care (In-Network and Out-of-Network Services Combined) *A visit includes one or more chiropractic services rendered by one provider in a day, but does not include a visit where the only service that the covered person received was chiropractic X-rays.				
Durable Medical Equipment, Prosthetics, and Orthotics	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Rehabilitative Services Physical Therapy, Speech Therapy, and Occupational Therapy 60 Outpatient Visits Allowed per Covered Person per Benefit Year for Any and All Eligible Diagnoses/Conditions (In-Network and Out-of-Network Services Combined)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Behavioral Care (Includes Mental Health Care and Addictions Treatment) Inpatient/Partial Hospitalization Services Outpatient/Intensive Outpatient Services, Including Telemedicine E-Visits	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Special Note about the Behavioral Care Benefit: In the event that a co-payment applies to an eligible outpatient/intensive outpatient provider fee for an office visit, the Primary Care Provider co-payment will be charged.				
Diagnosis or Treatment of Underlying Cause of Infertility	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Special Note about Infertility Coverage: The Plan does not cover infertility treatment services or prescription drugs, except to the extent a service is being provided to diagnose or treat any underlying cause(s) of infertility.				
Convalescent Care and Home Health Care	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible	80% after deductible	60% after deductible

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Miscellaneous Plan Provisions

Services Requiring Certification:

1. Inpatient hospital confinements and observational stays
2. Select surgical procedures (a list of surgical procedures requiring certification can be accessed by logging on to www.asrhealthbenefits.com or by calling ASR Health Benefits at 800-968-2449)
3. Durable medical equipment if the purchase price or forecasted total rental cost will be $2,500 or more
4. Home health care
5. Custom-made orthotic or prosthetic appliances if the purchase price will be $2,500 or more
6. Oncology treatment
7. Enteral and total parenteral nutrition therapy
8. Outpatient infusion or injection of select products if the per-dosage cost will be $2,000 or more per 30-day supply*

*A covered person can call the Certification telephone number on the health plan identification card to determine if a prescribed medication is subject to the Certification Requirement.

As required by the No Surprises Act, if a covered person receives services in the following situations, the services will be paid at the in-network benefit level: (1) Emergency care; (2) Transportation by air ambulance; or (3) Nonemergency care at an in-network facility provided by an out-of-network physician or laboratory, unless the covered person provides informed consent.

Additionally, if a covered person receives eligible treatment at an in-network facility, any charges for the following will be paid at the in-network benefit level, even if provided by an out-of-network physician or laboratory:
(1) Anesthesiology, pathology, radiology, or neonatology; (2) Assistant surgeons, hospitalists, or intensivists; (3) Diagnostic services (including radiology and laboratory services); and (4) Items and services provided by an out-of-network physician or laboratory if there was no in-network physician or laboratory that could provide the item or service at the in-network facility.

If a covered person receives treatment from an out-of-network provider and the Plan Administrator determines that treatment was not provided by an in-network provider for one of the reasons specified below, the claim may be adjusted to yield in-network-level benefits:

A. There is not access to a Qualified in-network provider located within a Reasonable Distance from the covered person's residence.

B. It was not reasonable for the covered person to seek care from an in-network provider because of a medical emergency.

C. A covered person either traveled to a place where he or she could not reasonably be expected to know the location of the nearest in-network provider or traveled to a place where no in-network providers are available.

D. A covered person receives eligible treatment at an in-network facility and he or she had no choice over the physician that provides treatment.

The term "Qualified" as used above means having the skills and equipment needed to adequately treat the covered person's condition. The term "Reasonable Distance" as used above approximates a 50-mile radius.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents

In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Special Note for Individuals Contributing to a Health Savings Account (HSA)

If an individual enrolled in the Plan 2 PPO Plan is also enrolled in a high-deductible health plan (HDHP) through a spouse's employer or another source and that person contributes to a health savings account (HSA), enrollment in the Plan 2 PPO Plan, which is not an HDHP, will render that individual ineligible to contribute to an HSA for the entire plan year.

Health Savings Account (HSA)

Individuals enrolled in the Plan 2 HDHP/HSA Plan may be eligible to establish and maintain a health savings account (HSA). The terms of the HSA are governed by Section 223 of the Internal Revenue Code and the terms of the trust or custodial agreement establishing the HSA. Funds contributed to an HSA are not subject to federal income tax at the time of deposit and can be rolled over and accumulated from year to year if not spent. HSA funds can be used to purchase qualified medical expenses, for example, the cost of a doctor's office visit or a prescription drug. In 2025, you may contribute up to **$4,300** for single coverage or **$8,550** for family coverage to an HSA. Additional catch-up contributions (**$1,000**) may be made if you are age 55 or older.

An individual who contributes to an HSA should not participate in a non-HDHP for the entire plan year in which the contributions are made in order to be eligible for the HSA.

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Benefit Description	Plan 2 PPO Plan Prescription Drug Benefit
Prescription Drugs Retail Prescription Drug Co-payments (30-Day Supply) A covered person may fill a prescription for up to and including a 30-day supply for the co-payment amounts shown. If a prescribing physician requests more than a 30-day supply of a drug, up to a 90-day supply of a covered prescribed medication can be purchased at a participating pharmacy for three times the applicable stated co-payment.	$10/Rx Formulary Tier 1 drug, $20/Rx Formulary Tier 2 drug, $40/Rx Formulary Tier 3 drug Specialty Prescription Drugs are eligible. Please call TransparentRx at (866) 499-1940 (option 1) for assistance with Specialty Prescription Drugs (including information about the co-payment that will be charged and other special terms that may apply). There is generally no prescription drug coverage for non-formulary drugs.
Mail-Order Prescription Drug Co-payments (90-Day Supply)	$10/Rx Formulary Tier 1 drug, $20/Rx Formulary Tier 2 drug, $40/Rx Formulary Tier 3 drug Specialty Prescription Drugs are eligible. Please call TransparentRx at (866) 499-1940 (option 1) for assistance with Specialty Prescription Drugs (including information about the co-payment that will be charged and other special terms that may apply). There is generally no prescription drug coverage for non-formulary drugs.

Special Notes about Prescription Drug Coverage:

1. The Plan's Pharmacy Benefits Manager (PBM) maintains lists of preferred and non-preferred generic and brand-name prescription drugs, and a drug's co-payment is determined by the drug's categorization in these lists. The term "Rx Formulary Tier 1" means a category of prescription drugs that generally includes most generic drugs and may include some low-cost brand-name drugs. The term "Rx Formulary Tier 2" means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs. The term "Rx Formulary Tier 3" means a category of prescription drugs that generally includes all non-preferred drugs. For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the covered person can contact the PBM using the information shown on the health plan identification card.

2. The PBM has classified some drugs new to the market as non-formulary drugs. **There is generally no prescription drug coverage for non-formulary drugs**. Covered persons should contact the PBM using the phone number on the health plan identification card for additional information about the coverage status of a particular drug.

3. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the co-payments shown above. A physician's prescription for these products is required.

4. The Plan generally provides coverage for certain Specialty Prescription Drugs as specified in the Prescription Agreement between the employer and the PBM; however, special rules may apply in order for such drugs to be covered. Covered persons prescribed a Specialty Prescription Drug should contact the PBM at the number on the health plan identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. As used in this benefit, the term "Specialty Prescription Drug" means a prescription drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty Prescription Drugs may be injectable medications, high-cost medications, or medications with special delivery and storage requirements (e.g., they may require refrigeration). Specialty Prescription Drug purchases will be limited to a 30-day supply, and prescriptions for Specialty Prescription Drugs must generally be filled through AllianceRx Walgreens Prime specialty pharmacy, shipped directly from the manufacturer, or otherwise coordinated through the TransparentPAP Patient Assistance Program; otherwise, the drug will not be eligible for coverage under the Plan.

5. **Generic drugs will be dispensed unless a generic equivalent is not available.** If an available generic equivalent is refused, even if the prescribing physician has requested "Dispense as Written" (DAW), the covered person will be required to pay the brand co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.

6. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as medical deductibles or prescription drug co-payments. For more information about eligible preventive care medications, the covered person can contact the PBM using the information shown on the health plan identification card.

7. The Plan requires that specific criteria be met before certain high-cost brand-name medications are covered. The covered person must have tried a lower-cost PBM-approved equivalent medication before the Plan will cover the brand-name drug. Alternatively, a brand-name drug may be covered if the covered person's physician contacts the PBM and provides evidence of the prior utilization or proof of failed therapy and the PBM authorizes the brand-name medication. If a covered person chooses to fill a prescription for certain brand-name drugs without first trying a PBM-approved equivalent medication or getting an authorization from the PBM, coverage may be denied and the covered person may have to pay the full cost of the drug.

8. This benefit will cover charges (including serum and injection fee charges) for certain immunizations when administered at a pharmacy at 100% with no medical deductible or prescription drug co-payment applied. For more information about eligible immunizations, the covered person can contact the PBM using the information shown on the health plan identification card.

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Benefit Description	Plan 2 HDHP/HSA Plan Prescription Drug Benefit
Prescription Drugs Drugs Purchased Before the In-Network Medical Deductible is Satisfied • Preventive Drugs In general, a drug is deemed "preventive" when it is taken by an individual who has developed risk factors for the disease that has not yet become clinically apparent, or to prevent the recurrence of a disease after the individual's recovery. The Pharmacy Benefits Manager (PBM) has developed and maintains a standard list of preventive drugs. This list is separate from the preventive care medication coverage requirements set forth by Health Care Reform (see the notes section below for more information on these items).	The applicable co-payments and day-supply limits described below apply (medical deductible waived). The co-payment charged will depend on the type of medication, whether the drug is a preferred brand, non-preferred brand, or generic medication, and the dosage.
All Other Eligible Drugs (Non-Preventive Drugs)	The covered person must pay the full cost of the prescription at the time of purchase. The amount paid to purchase an eligible prescription drug will apply toward the in-network medical deductible. If an eligible prescription drug is purchased at a pharmacy within the appropriate network, through the Mail Service Program, or through the specialty pharmacy, the covered person may receive a discount toward the purchase price of the drug. The availability and amount of the discount will depend on the type of medication, whether the drug is brand-name or generic, and the dosage.
Drugs Purchased After the In-Network Medical Deductible is Satisfied Retail or Mail Order Prescription Drug Co-payments (90-Day Supply)	20% of purchase price/drug Specialty Prescription Drugs are eligible. Please call TransparentRx at (866) 499-1940 (option 1) for assistance with Specialty Prescription Drugs (including information about the co-payment that will be charged and other special terms that may apply) There is generally no prescription drug coverage for non-formulary drugs.
Drugs Purchased After the In-Network Medical Total Maximum Out-of-Pocket is Satisfied	Plan pays 100% of the purchase price; no co-payment applies

Special Notes about Prescription Drug Coverage:

1. The PBM has classified some drugs new to the market as non-formulary drugs. **There is generally no prescription drug coverage for non-formulary drugs**. Covered persons should contact the PBM using the phone number on the health plan identification card for additional information about the coverage status of a particular drug.

2. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the co-payments shown above after the in-network medical deductible has been met. After the in-network medical Total Maximum Out-of-Pocket is met, no co-payment shall apply for the rest of the Benefit Year. A physician's prescription for these products is required.

3. The Plan generally provides coverage for certain Specialty Prescription Drugs as specified in the Prescription Agreement between the employer and the PBM; however, special rules may apply in order for such drugs to be covered. Covered persons prescribed a Specialty Prescription Drug should contact the PBM at the number on the health plan identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. As used in this benefit, the term "Specialty Prescription Drug" means a prescription drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty Prescription Drugs may be injectable medications, high-cost medications, or medications with special delivery and storage requirements (e.g., they may require refrigeration). Specialty Prescription Drug purchases will be limited to a 30-day supply, and prescriptions for Specialty Prescription Drugs must generally be filled through AllianceRx Walgreens Prime specialty pharmacy, shipped directly from the manufacturer, or otherwise coordinated through the TransparentPAP Patient Assistance Program; otherwise, the drug will not be eligible for coverage under the Plan.

4. **Generic drugs will be dispensed unless a generic equivalent is not available.** If an available generic equivalent is refused, even if the prescribing physician has requested "Dispense as Written" (DAW), the covered person will be required to pay the brand co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.

5. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as medical deductibles or prescription drug co-payments. For more information about eligible preventive care medications, the covered person can contact the PBM using the information shown on the health plan identification card.

6. The Plan requires that specific criteria be met before certain high-cost brand-name medications are covered. The covered person must have tried a lower-cost PBM-approved equivalent medication before the Plan will cover the brand-name drug. Alternatively, a brand-name drug may be covered if the covered person's physician contacts the PBM and provides evidence of the prior utilization or proof of failed therapy and the PBM authorizes the brand-name medication. If a covered person chooses to fill a prescription for certain brand-name drugs without first trying a PBM-approved equivalent medication or getting an authorization from the PBM, coverage may be denied and the covered person may have to pay the full cost of the drug.

7. This benefit will cover charges (including serum and injection fee charges) for certain immunizations when administered at a pharmacy at 100% with no medical deductible or prescription drug co-payment applied. For more information about eligible immunizations, the covered person can contact the PBM using the information shown on the health plan identification card.

This brochure represents only a summary of your group health benefits Plan as it applies to all eligible employees and dependents. This brochure is not the Plan Document or the Summary Plan Description for ERISA purposes and shall not be relied upon to establish or determine eligibility, benefits, procedures, or the content or validity of any section or provision of the Health Benefits Plan. Please refer to the Health Benefits Plan Document for specific information regarding Plan provisions.