L'Oreal Travel Retail Americas Health Benefit Plan **PPO Medical Plan**
Medical Schedule of Benefits **Effective January 1, 2020**

Refer to the Plan Document and Summary Plan Description for details of Coverage.

Medical Benefits	CIGNA PPO Providers	Non-PPO Providers
Calendar Year Deductible	$100 per individual. $300 per family (accumulative).	$5,000 per individual. $10,000 per family (accumulative).
	Calendar Year deductible does not include Co-payments.	
Coinsurance	90% of covered expenses.	70% of covered expenses.
	Refer to Health Reimbursement Account (HRA) benefit for partial reimbursement of Coinsurance related expenses.	
Out-of-Pocket Maximum PPO and Non-PPO Out-of-Pocket Maximums shall combine together.	$3,000 per individual. $7,000 per family (accumulative).	$5,000 per individual. $10,000 per family (accumulative).
	Out-of-pocket expenses include Medical Co-payments, Coinsurance and the Calendar Year Deductible. Non-covered expenses, pre-certification penalties and Rx Co-payments do not apply toward the Out-of-Pocket Maximum.	
Lifetime Overall Maximum Benefit	Unlimited.	
Health Reimbursement Account (HRA)	The HRA will pay 50% of all Coinsurance related out-of-pocket expenses up to $1,500 per individual / $4,500 per family on an accumulative basis.	
Alcohol & Substance Abuse Services	**Inpatient / Partial Hospitalization:** 90% Coinsurance; subject to Calendar Year deductible.	**Inpatient / Partial Hospitalization:** 70% Coinsurance; subject to Calendar Year deductible.
	Outpatient Services: 100% of eligible charges following a $40 Co-payment; not subject to Calendar Year deductible.	**Outpatient Services:** 70% Coinsurance; subject to Calendar Year deductible.
Allergy Injections	100% of covered expenses; not subject to the Calendar Year deductible.	90% Coinsurance; subject to Calendar Year deductible.
Ambulance Services	90% Coinsurance; subject to Calendar Year deductible.	90% Coinsurance; subject to Calendar Year deductible.
Birthing Center	90% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Chiropractic Care / Spinal Manipulation	100% of eligible charges following a $30 Co-payment; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Calendar Year maximum benefit of 26 visits.	
Durable Medical Equipment	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Emergency Room Services	100% of eligible charges following a $150 Co-payment.	70% Coinsurance following a $150 Co-payment; subject to Calendar Year deductible.
Extended Care Facility	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Calendar Year maximum benefit of 60 days. Extended Care Facility also includes Rehabilitation Hospital & Skilled Nursing Facility services.	
Home Health Care	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Calendar Year maximum benefit of 60 visits.	
Hospice Care	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

Medical Benefits	CIGNA PPO Providers	Non-PPO Providers
Maternity Care	Initial diagnosis / office visit charge is payable at 100% of eligible charges following a $30 Co-payment; not subject to Calendar year deductible. Physician obstetrical fee for all pre-natal care and delivery shall be payable at 90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Mental Health Services	**Inpatient / Partial Hospitalization:** 90% Coinsurance; subject to Calendar Year deductible.	**Inpatient / Partial Hospitalization:** 70% Coinsurance; subject to Calendar Year deductible.
	Outpatient Services: 100% of eligible charges following a $30 Co-payment; not subject to Calendar Year deductible.	**Outpatient Services:** 70% Coinsurance; subject to Calendar Year deductible.
Outpatient Diagnostic Services	**Ambulatory Facility:** 100% of eligible charges following a $100 Co-payment; not subject to Calendar Year deductible. **Hospital based facility:** 90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Includes CT Scans, PET Scans, MRI and Endoscopy.	
Outpatient X-Ray & Laboratory Services	100% of covered expenses; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	For complex diagnostic services such as CT Scans, PET Scans, MRI and Endoscopy, please refer to Outpatient Diagnostic Services.	
Outpatient Physician Office Visit Services	**Teladoc Physician Consultation:** 100% of eligible expenses following a $20 Co-payment; not subject to Calendar Year deductible. **Primary Care Physician / Specialist Office Visit:** 100% of eligible charges following a $30 Co-payment; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Includes office visit charges, x-ray, laboratory, diagnostic services, supplies & minor surgical procedures performed in the Physician's office during the office visit. Refer to Outpatient X-Ray & Laboratory benefit for services rendered outside of the Physicians office.	
Outpatient Surgery Applies to Surgery performed outside of a Physician's office.	**Ambulatory Surgical Facility:** 100% of eligible charges following a $100 Co-payment; not subject to Calendar Year deductible. **Hospital based facility:** 90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Outpatient Therapy Services	100% of eligible charges following a $30 Co-payment; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible and Calendar Year maximum benefit.
	Calendar Year maximum benefit of 60 visits per condition. Includes Occupational Therapy, Physical Therapy and Speech Therapy.	
Podiatry Services	100% of eligible charges following a $30 Co-payment; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Calendar Year maximum benefit of 25 visits.	
Pre-Admission Testing	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Pre-Certification Requirements	Pre-admission certification for an elective non-emergency hospital admission is mandatory. Emergency admissions must be approved within 48 hours. Failure to comply will reduce all eligible facility charges by 20%.	

Medical Benefits	CIGNA PPO Providers	Non-PPO Providers
Prescription Drug Benefits Retail Prescriptions (30 day supply maximum) Mail Order Prescriptions (90 day supply maximum) Specialty Drugs (30 day supply maximum)	**Prescription Drug Card:** ▪ Generic drugs: $10 Co-payment ▪ Formulary Brand: $20 Co-payment* ▪ Non-Formulary Brand: $30 Co-payment* *Mandatory Generic requirement unless Medically Necessary **Mail Order Prescriptions:** ▪ Generic drugs: $15 Co-payment ▪ Formulary Brand: $30 Co-payment ▪ Non-Formulary Brand: $45 Co-payment **Specialty Drug Program:** 100% of covered expenses following a $75 Co-payment; not subject to Calendar Year deductible. Note: Filling of Specialty Drugs will be coordinated through Preferred Benefit Admin.	Prescriptions purchased from Non-Participating Pharmacies or outside of the Mail Order Drug Program are not eligible for reimbursement through the Plan.
Prosthetic Devices	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; not subject to Calendar Year deductible.
Routine Well Adult Care (Age 17 and above)	100% of eligible charges (no Co-payment applies); not subject to Calendar Year deductible.	70% Coinsurance; not subject to Calendar Year deductible.
	Includes physician charges and all related services for routine exams, immunizations, mammograms & prostate screenings. This benefit also includes routine colonoscopy expenses for members age 50+.	
Routine Well Child Care (Birth through age 16)	100% of eligible charges (No Co-payment applies); not subject to Calendar Year deductible.	70% Coinsurance; not subject to Calendar Year deductible.
	Includes Office Visit charges, immunizations, laboratory / blood tests & routine vision & hearing screenings.	
Second Surgical Opinion	100% of eligible charges following a $30 Co-payment.	70% Coinsurance; subject to Calendar Year deductible.
Transplant Benefit	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Refer to the Plan Document for specific information regarding this benefit.	
Urgent Care Facility Services	100% of eligible charges following a $50 Co-payment; not subject to Calendar Year deductible.	100% of eligible charges following a $100 Co-payment; not subject to Calendar Year deductible.
All Other Covered Medical Expenses	90% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

Coverage and Benefit questions should be directed to:

Preferred Benefit Administrators
PO Box 916188 Longwood, FL 32791-6188
407-786-2777 or 888-524-2777 **www.PreferredTPA.com**

Preferred BENEFIT ADMINISTRATORS INCORPORATED

Important Notice to Plan All Participants

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to our Claims Administrator:

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188
(407)786-2777 or (888)524-2777

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.