JNE MANAGEMENT HEALTH BENEFIT PLAN **HOURLY EMPLOYEE PLAN**
Medical Summary of Benefits **Effective November 1, 2021**

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

BENEFITS	CIGNA PPO PROVIDERS (www.Cigna.com)	NON-PPO PROVIDERS
Member Calendar Year Deductible Calendar Year deductible does not include Co-payments.	$5,500 per individual* $11,000 per family* (accumulative)	$9,000 per individual $18,000 per family (accumulative)
	***Important Note: Your Calendar Year Deductible will be reduced by $500 if you contact the Medical Advocate Program (MAP) prior to scheduling your appointment. Medical Advocate Program (MAP): 1-888-289-0700**	
Plan Coinsurance	70% of covered expenses after Calendar Year deductible is satisfied.	50% of covered expenses after Calendar Year deductible is satisfied.
Member Out-of-Pocket Maximum PPO and Non-PPO Out-of-Pocket Maximums shall combine together.	$7,900 per individual $15,800 per family (accumulative)	Unlimited
	Out-of-pocket expenses include the Calendar Year deductible, Medical Plan Co-payments, Prescription Co-payments and Coinsurance. Non-covered expenses & pre-certification penalties DO NOT apply toward the Out-of-Pocket Maximum.	
Lifetime Maximum Benefit	Unlimited	
Accidental Injury Benefit	100% of covered expenses up to $300 per accident for treatment rendered within 90 days of an accident; not subject to Calendar Year deductible. Treatment rendered after 90 days or expenses exceeding the $300 benefit shall be payable based upon the treatment rendered.	
Alcohol & Substance Abuse Treatment	**Inpatient / Partial Hospitalization:** 70% of eligible expenses; subject to Calendar Year deductible.	**Inpatient / Partial Hospitalization:** 50% Coinsurance; subject to Calendar Year deductible.
	Outpatient Services: 100% of eligible charges following a $100 Co-payment per visit.	**Outpatient Services:** 50% Coinsurance; subject to Calendar Year deductible.
Allergy Services	**Allergy Injections:** 100% of covered expenses following a $10 Co-payment per visit. **Allergy Testing:** 70% of covered expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Ambulance Services	70% of covered expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Birthing Center	70% of covered expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Dental Services (Accident Only)	70% of covered expenses; subject to Calendar Year deductible. Overall Calendar Year maximum benefit of $3,000 and $900 per tooth.	
Durable Medical Equipment	70% of covered expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Emergency Room Services	80% of eligible expenses following a $1,000 Co-payment. The Co-payment will be waived if the patient is admitted to the Hospital from the Emergency Room.	
Extended Care Facility	70% of eligible expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
	Extended Care Facility also includes Rehabilitation Hospital & Skilled Nursing Facility services.	
Hearing Aid Benefit	70% of eligible expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
	Limited to $2,500 every 3 Years.	
Home Health Care	70% of eligible expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Hospice Care	70% of eligible expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services Includes Physician Services	70% of eligible expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.

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Mammogram Screening	100% of eligible expenses; not subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Maternity Care	Initial diagnosis and office visit is payable at 100% following a $50 Co-payment; Physician obstetrical fee for all pre-natal care and delivery shall be payable at 70% subject to the Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Mental Health Services	**Inpatient / Partial Hospitalization:** 70% of eligible expenses; subject to Calendar Year deductible.	**Inpatient / Partial Hospitalization:** 50% Coinsurance; subject to Calendar Year deductible.
	Outpatient Services: 100% of eligible charges following a $100 Co-payment per visit.	**Outpatient Services:** 50% Coinsurance; subject to Calendar Year deductible.
Ostomy Supplies	70% of eligible expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
	Calendar Year maximum benefit of $2,500.	
Outpatient Diagnostic Services Includes CT Scans, PET Scans and MRI.	100% of eligible expenses following a $500 Co-payment* per scan.	50% Coinsurance; subject to Calendar Year deductible.
	***Important Note: The Outpatient Diagnostic Services Co-pay will be reduced to $200 per scan if you contact the Medical Advocate Program (MAP) prior to scheduling your appointment. Medical Advocate Program (MAP): 1-888-289-0700**	
Outpatient Laboratory & X-Ray Services	70% of eligible expenses; not subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
	For complex diagnostic services such as CT Scans, PET Scans and MRI refer to Outpatient Diagnostic Services benefit.	
Outpatient Physician Office Visit Services Refer to Outpatient X-Ray & Laboratory Services benefit for treatment rendered outside of the Physicians office.	**Teladoc Physician Consultation:** 100% of eligible expenses; Co-payment waived. **Primary Physician Office Visit:** 100% of eligible charges following a $50 Co-payment. **Specialist Physician Office Visit:** 100% of eligible charges following a $100 Co-payment.	50% 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.	
Outpatient Surgery (Outside of Physicians office)	70% of covered expenses; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Outpatient Therapy Services	100% of eligible charges following a $50 Co-payment.	50% Coinsurance; subject to Calendar Year deductible.
	▪ Occupational Therapy ▪ Chiropractic/Manipulative Treatment ▪ Physical Therapy ▪ Pulmonary Rehabilitation ▪ Speech Therapy ▪ Post-cochlear Implant Aural Therapy ▪ Cardiac Rehabilitation	
Pre-Admission Testing	70% of eligible expenses; subject to Calendar Year deductible.	50% 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%.	
Prescription Drug Benefits Retail Prescriptions (31 day supply maximum) Mail Order Prescriptions (90 day supply maximum)	**Prescription Drug Card:** ▪ Generic drugs: $10 Co-payment ▪ Formulary Brand: $50 Co-payment ▪ Non-Formulary Brand: $80 Co-payment **Mail Order Prescriptions:** ▪ Generic drugs: $20 Co-payment ▪ Formulary Brand: $100 Co-payment ▪ Non-Formulary Brand: $160 Co-payment **Specialty Prescriptions:** 50% up to a maximum of $200 per Rx	Prescriptions purchased from Non-Participating Pharmacies or outside of the Mail Order Drug Program are not eligible for reimbursement through the Plan.

<table>
<tr><th>BENEFITS</th><th>CIGNA PPO PROVIDERS
(www.Cigna.com)</th><th>NON-PPO PROVIDERS</th></tr>
<tr><td>Prosthetic Devices</td><td>70% of covered expenses; subject to Calendar Year deductible.</td><td>50% Coinsurance; subject to Calendar Year deductible.</td></tr>
<tr><td rowspan="2">Routine Well Adult Care

(Age 18 and above) Includes physician charges and related laboratory charges for annual routine preventive examinations and the specific preventive services outlined.</td><td>100% of eligible charges.</td><td>50% Coinsurance; subject to Calendar Year deductible.</td></tr>
<tr><td colspan="2">This routine benefit includes physician charges for an annual routine examination, Routine x-rays & laboratory, immunizations, Mammograms and other Routine services listed below:
▪ Immunizations.
▪ Fasting lipoprotein profile (cholesterol screening).
▪ Annual Prostate Specific Antigen (PSA) screening.
▪ Fasting blood sugar screening (for diabetes mellitus).
▪ Annual colorectal screening.
▪ Colonoscopy (limited to 1every 10 years for age 50+).
▪ Blood pressure screening.
▪ Annual hearing examination as part of routine annual exam by PCP.
▪ Annual vision screening as part of routine annual exam by PCP.
▪ Annual mammogram screening.
▪ EKG.
▪ Bone Mineral Density (BMD) screening (once every 24 months).
▪ Women’s Health Services to include pelvic exam and Pap test; screening for gestational diabetes; DNA Testing; HPV (Human Papillomavirus); counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; and contraceptive methods and counseling. Limitations may apply.
A complete list of covered ACA mandated routine services for women & adults is available at:
https://www.healthcare.gov/coverage/preventive-care-benefits/</td></tr>
<tr><td rowspan="2">Routine Well Child Care

(Birth through age 17)</td><td>100% of eligible charges.</td><td>50% Coinsurance; not subject to Calendar Year deductible.</td></tr>
<tr><td colspan="2">Includes Office Visit charges, immunizations, lab / blood tests & routine vision & hearing screenings.
A complete list of covered ACA mandated routine services for children is available at:
https://www.healthcare.gov/coverage/preventive-care-benefits/</td></tr>
<tr><td rowspan="2">Scopic Procedures</td><td>70% of covered expenses; subject to Calendar Year deductible.</td><td>50% Coinsurance; subject to Calendar Year deductible.</td></tr>
<tr><td colspan="2">Includes, but is not limited to: Colonoscopy, Sigmoidoscopy, Endoscopy</td></tr>
<tr><td>Transplant Benefit</td><td>70% of covered expenses; subject to Calendar Year deductible. Services must be received at a designated transplant facility.</td><td>50% Coinsurance; subject to Calendar Year deductible.</td></tr>
<tr><td rowspan="2">Urgent Care Facility Services</td><td>100% of eligible charges following a $75 Co-payment.</td><td>50% Coinsurance; subject to Calendar Year deductible.</td></tr>
<tr><td colspan="2">For complex diagnostic services such as CT Scans, PET Scans and MRI refer to Outpatient Diagnostic Services benefit.</td></tr>
<tr><td rowspan="2">Vision Examinations</td><td>100% of eligible charges following a $50 Co-payment.</td><td>50% Coinsurance; subject to Calendar Year deductible.</td></tr>
<tr><td colspan="2">Limited to one exam every 2 years.</td></tr>
<tr><td>All Other Covered Medical Expenses</td><td>70% of covered expenses; subject to Calendar Year deductible.</td><td>50% Coinsurance; subject to Calendar Year deductible.</td></tr>
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Questions regarding Coverage / Benefits should be directed to:

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Preferred
BENEFIT ADMINISTRATORS
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