**WILLIAMS COMPANY MANAGEMENT GROUP HEALTH BENEFIT PLAN** **HSA Medical Plan**
**Medical Summary of Benefits** **Effective January 1, 2022**

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

| MEDICAL BENEFITS | Cigna PPO Network Providers | Non-PPO Providers |
|---|---|---|
| **Calendar Year Deductible** | $1,500 per individual<br>$3,000 per family | $3,000 per individual<br>$6,000 per family |
| | **Note:** Family Coverage refers to an Employee plus one or more Dependents. If an Employee is enrolled for Family Coverage the Family deductible must be met before any claims are paid. The total Family deductible may be met by claims of one or more individuals.<br>The Calendar Year deductible does NOT include pre-certification penalties, non-covered expenses or charges in excess of Reasonable & Customary charges.<br>PPO & Non-PPO deductibles do NOT accumulate towards one another. | |
| **Coinsurance** | 90% of covered expenses | 60% of covered expenses |
| **Out-of-Pocket Maximum** | $3,000 per individual<br>$6,000 per family | There is no Out-of-Pocket Maximum when Non-PPO Providers are utilized. |
| | **Note:** Each member will be responsible for satisfying no more than the individual Out-of-Pocket maximum, however, if enrolled for Family Coverage the family Out-of-Pocket maximum can be met by a combination of all family members or by any two individuals within the family. Once the family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum.<br>The Out-of-Pocket Maximum includes the Calendar Year deductible, Coinsurance and Prescription Co-payments. Pre-certification penalties, non-covered expenses and charges in excess of Reasonable & Customary charges shall not apply towards the Out-of-Pocket Maximum.<br>PPO & Non-PPO Out-of-Pocket Maximums do NOT accumulate towards one another. | |
| **Lifetime Maximum Benefit** | Unlimited. | |
| **Alcohol & Substance Abuse Treatment**<br>Inpatient confinement requires Pre-certification | **Inpatient / Partial Hospitalization:** 90% Coinsurance; subject to Calendar Year deductible.<br>**Outpatient Services:** 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |
| **Allergy Injections & Testing** | **Allergy Injections:** 90% Coinsurance; subject to Calendar Year deductible.<br>**Allergy Testing:** 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |
| **Ambulance Services** | 90% Coinsurance; subject to Calendar Year deductible. | 90% Coinsurance; subject to PPO Network Calendar Year deductible. |
| **Chiropractic Services / Spinal Manipulation** | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |
| | Calendar Year maximum of 26 visits; accumulates toward Outpatient Therapy maximum benefit. | |
| **Durable Medical Equipment & Supplies**<br>Requires Pre-certification | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |
| **Emergency Room Services** | 90% Coinsurance; subject to Calendar Year deductible. | 90% Coinsurance; subject to Calendar Year deductible. |
| **Extended Care Facility**<br>Requires Pre-certification | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |
| | Calendar Year maximum benefit of 60 days for Skilled Nursing Facility.<br>Calendar Year maximum benefit of 30 days for inpatient Rehabilitation Facility. | |
| **Home Health Care**<br>Requires Pre-certification | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |
| | Calendar Year maximum of 20 visits. | |
| **Hospice Care**<br>Requires Pre-certification | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |
| **Inpatient Hospital Services**<br>(Includes Physician Services)<br>Requires Pre-certification | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible.<br>Physician Services: 90% Coinsurance; subject to PPO Network Calendar Year deductible |
| **Maternity Care** | **Initial Maternity Office Visit:** 90% Coinsurance; subject to Calendar Year deductible.<br>**Pre-natal & Post-natal Care, Delivery and all inpatient Hospital services:** 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |

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| **Mental Health Services**<br>Inpatient confinement requires Pre-certification | **Inpatient / Partial Hospitalization:** 90% Coinsurance; subject to Calendar Year deductible.<br>**Outpatient Services:** 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance;<br>subject to Calendar Year deductible. |
| **Outpatient Imaging / X-Ray Services** | **Diagnostic Imaging / X-Rays (not complex):**<br>(Outpatient Hospital or other outpatient facility) | |
| | **Independent Imaging Facility:** 90% Coinsurance; subject to Calendar Year deductible.<br>**Outpatient Hospital:** 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance;<br>subject to Calendar Year deductible. |
| | **Complex Imaging Services*:**<br>(Includes but is not limited to CT scans, MRI's, MRA's, PET scans and nuclear cardiology in any location, including the Physician's office) | |
| *Complex Imaging requires Pre-certification | 90% Coinsurance;<br>subject to Calendar Year deductible. | 60% Coinsurance;<br>subject to Calendar Year deductible. |
| **Outpatient Laboratory Services** | **Independent Clinical Laboratory:** 90% Coinsurance; subject to Calendar Year deductible.<br>**Outpatient Hospital:** 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance;<br>subject to Calendar Year deductible. |
| **Outpatient Physician Office Visit Services**<br>Includes office visit charges, standard x-ray, minor surgical procedures, laboratory and diagnostic services performed in the Physician's office during the office visit.<br>Refer to Outpatient Surgery benefit for surgical procedures performed outside of a Physicians office. | ▪ **Primary Care Office Visit / Walk in Clinic:** 90% Coinsurance; subject to Calendar Year deductible.<br>▪ **Specialist Office Visit:** 90% Coinsurance; subject to Calendar Year deductible.<br>▪ **e-Office Visit:** 90% Coinsurance; subject to Calendar Year deductible.<br>▪ **Urgent Care Provider:** 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance;<br>subject to Calendar Year deductible. |
| | Refer to Outpatient Laboratory Services benefit and Outpatient Imaging / X-Ray Services benefit for treatment rendered outside of the Physician's office and for CT scans, MRI's, MRA's and PET scans in any location, including the Physician's office. | |
| **Outpatient Surgery**<br>Covered cosmetic surgical procedures require Pre-certification | **Ambulatory Surgical Center Facility:** 90% Coinsurance; subject to Calendar Year deductible.<br>**Outpatient Hospital:** 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance;<br>subject to Calendar Year deductible. |
| **Outpatient Therapy Services** | 90% Coinsurance;<br>subject to Calendar Year deductible. | 60% Coinsurance;<br>subject to Calendar Year deductible. |
| | Combined Calendar Year maximum of 35 visits for all rehabilitative therapy including Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic Treatment, Massage Therapy and Cardiac Rehabilitation. | |
| **Pre-Certification for Inpatient Hospital Admissions and Other Required Services** | Pre-admission certification is mandatory for inpatient Hospital Admissions, Hospice Care, Extended Care Facility confinements, Complex Imaging, Home Health Care, Durable Medical Equipment and covered cosmetic surgical procedures outlined in the Plan Document. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a $500 reduction of benefits due to pre-certification non-compliance. | |
| **Prescription Drug Benefits**<br>▪ Retail Prescriptions (30 day supply maximum)<br>▪ Mail Order Prescriptions (90 day supply maximum) | **After the Calendar Year Deductible has been met, the following Co-payments will apply:**<br>**Retail Network Pharmacy Co-payments:**<br>▪ Generic medications: $10 Co-pay<br>▪ Formulary Brand medications: $50 Co-pay<br>▪ Non-Formulary Brand medications: $80 Co-pay<br>**Mail Order Prescription Co-payments:**<br>▪ Generic medications: $25 Co-pay<br>▪ Formulary Brand medications: $125 Co-pay<br>▪ Non-Formulary Brand medications: $200 Co-pay<br>**Specialty / Injectible Prescription Co-pay:**<br>Retail Co-payments listed above shall apply. | 60% Coinsurance; subject to Calendar Year deductible. |
| **Prosthetic Appliances** | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |

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| **Routine Colonoscopy** | 100% of covered expenses; not subject to Calendar Year deductible.<br>Age and frequency schedule apply. | |
| **Routine Mammogram** | 100% of covered expenses; not subject to Calendar Year deductible.<br>Age and frequency schedule apply. | |
| **Routine Well Adult Care**<br>(Age 18 and above) | 100% of covered expenses; not subject to Calendar Year deductible. | 60% Coinsurance; not subject to Calendar Year deductible. |
| | This routine benefit includes, but is not limited to, physician charges for an annual routine examination, routine x-rays and laboratory, immunizations and the routine services listed below:<br>▪ Immunizations.<br>▪ Fasting lipoprotein profile (cholesterol screening).<br>▪ Annual Prostate Specific Antigen (PSA) screening.<br>▪ Fasting blood sugar screening (for diabetes mellitus).<br>▪ Annual colorectal screening.<br>▪ Bone Mineral Density (BMD) screening (once every 24 months).<br>▪ Blood pressure screening.<br>▪ Obesity screening and counseling.<br>▪ Tobacco use screening and cessation interventions.<br>▪ 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; sterilization; and contraceptive methods and counseling. Limitations may apply.<br>**A complete list of covered ACA mandated routine services for women / adults is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/** | |
| **Routine Well Child Care**<br>(Birth through age 17) | 100% of covered expenses; not subject to Calendar Year deductible. | 60% Coinsurance; not subject to Calendar Year deductible. |
| | Includes Office Visit charges, immunizations, laboratory blood tests, developmental screening, behavioral assessments, routine vision screening & hearing screening for newborns.<br>**A complete list of covered ACA mandated routine services for children is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/** | |
| **Transplant Benefit** | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |
| **All Other Covered Medical Expenses** | 90% Coinsurance; subject to Calendar Year deductible. | 60% Coinsurance; subject to Calendar Year deductible. |

**Questions regarding Coverage and/or Benefits should be directed to:**

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