KEMPHARM HEALTH BENEFIT PLAN **HSA Medical Plan**
Medical Plan 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 $3,000 per family	$3,000 per individual $6,000 per family
	Note: Each member will be responsible for satisfying no more than the individual deductible, however, if enrolled for Family Coverage the family deductible can be met by a combination of all family members or by any two individuals within the family. Once the family deductible is met, all family members will be considered as having met their Out-of-Pocket Maximum. The deductible does NOT include pre-certification penalties, non-covered expenses or charges in excess of Reasonable & Customary charges. PPO and Non-PPO deductibles shall combine together.	
Coinsurance	100% of covered expenses	100% of covered expenses
Out-of-Pocket Maximum	$1,500 per individual $3,000 per family	$3,000 per individual $6,000 per family
	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. The Out-of-Pocket Maximum includes deductible. Pre-certification penalties, non-covered expenses and charges in excess of Reasonable & Customary charges DO NOT apply toward the Out-of-Pocket Maximum. PPO and Non-PPO Out-of-Pocket Maximums shall combine together.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment Inpatient confinement requires Pre-certification	**Inpatient / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses; subject to Calendar Year deductible.	**Inpatient / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses; subject to Calendar Year deductible.
	Inpatient Calendar Year maximum benefit of 30 days; Outpatient Calendar Year maximum benefit of 52 days. (Maximum benefit levels are combined with Mental Health Services benefit)	
Allergy Injections & Testing	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Ambulance Services	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Chiropractic Services / Spinal Manipulation	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Durable Medical Equipment & Supplies	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Emergency Room Services	100% of covered expenses; subject to In-Network Calendar Year deductible.	
Extended Care Facility Requires Pre-certification	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
	Calendar Year maximum benefit of 90 days for Skilled Nursing Facility / inpatient Rehabilitation Facility.	
Home Health Care	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Hospice Care Requires Pre-certification	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
	Calendar Year maximum benefit: 15 days for inpatient respite care; 15 days of outpatient respite care.	
Inpatient Hospital Services Requires Pre-certification	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Maternity Care	**Initial Maternity Office Visit, Pre-natal & Post-natal Care, Delivery and all inpatient Hospital services:** 100% of covered expenses; subject to Calendar Year deductible.	**Initial Maternity Office Visit, Pre-natal & Post-natal Care, Delivery and all inpatient Hospital services:** 100% of covered expenses; subject to Calendar Year deductible.

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Mental Health Services Inpatient confinement requires Pre-certification	**Inpatient / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses; subject to Calendar Year deductible.	**Inpatient / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses; subject to Calendar Year deductible.
	Inpatient Calendar Year maximum benefit of 30 days; Outpatient Calendar Year maximum benefit of 52 days. (Maximum benefit levels are combined with Alcohol & Substance Abuse Treatment benefit)	
Outpatient Imaging / X-Ray Services	**Diagnostic Imaging / X-Rays (not complex):** (Outpatient Hospital or another outpatient facility)	
	Independent Imaging Facility: 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.	**Independent Imaging Facility:** 100% of covered expenses; subject to Calendar Year deductible **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
	Complex Imaging Services*: (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)	
	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Outpatient Laboratory Services	**Independent Clinical Laboratory:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.	**Independent Clinical Laboratory:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
Outpatient Physician Office Visit Services Includes office visit charges, standard x-ray, minor surgical procedures, laboratory and diagnostic services performed in the Physician's office during the office visit. Refer to Outpatient Surgery benefit for surgical procedures performed outside of a Physicians office.	**E-visit with Teladoc Health Physician: $0 Co-pay; not subject to Calendar Year deductible.**	
	Primary Care Office Visit / Walk in Clinic: 100% of covered expenses; subject to Calendar Year deductible. **Specialist Office Visit:** 100% of covered expenses; subject to Calendar Year deductible. **Urgent Care Provider:** 100% of covered expenses; subject to Calendar Year deductible.	**Primary Care Office Visit / Walk in Clinic:** 100% of covered expenses; subject to Calendar Year deductible. **Specialist Office Visit:** 100% of covered expenses; subject to Calendar Year deductible. **Urgent Care Provider:** 100% of covered expenses; subject to Calendar Year deductible.
	Refer to Outpatient Laboratory Services benefit and Outpatient Imaging / X-Ray Services benefit for treatment rendered outside of the Physicians office and for CT scans, MRI's, MRA's and PET scans in any location, including the Physician's office.	
Outpatient Surgery	**Ambulatory Surgical Center Facility:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.	**Ambulatory Surgical Center Facility:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
Outpatient Therapy Services	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Pre-certification for Inpatient Admissions	Pre-admission certification is mandatory for inpatient Hospital Admissions. 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 ▪ Retail Prescriptions (30 day supply maximum) ▪ Mail Order Prescriptions (90 day supply maximum)	**Retail Network Pharmacy:** 100% of covered expenses; subject to Calendar Year deductible. **Mail Order Prescriptions:** 100% of covered expenses; subject to Calendar Year deductible. **Specialty / Injectible Prescriptions:** 100% of covered expenses; subject to Calendar Year deductible.	Prescription drugs purchased from Non-Participating Pharmacies are not eligible for reimbursement by the Plan.

MEDICAL BENEFITS	Cigna PPO Network Providers	Non-PPO Providers
Prosthetic Appliances	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
Routine Colonoscopy	100% of covered expenses; not subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
	Age and frequency schedule apply.	
Routine Mammogram	100% of covered expenses; not subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
	Age and frequency schedule apply.	
Routine Well Adult Care (Age 18 and above)	100% of covered expenses; not subject to Calendar Year deductible.	100% of covered expenses; 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: ▪ Immunizations. ▪ Fasting lipoprotein profile (cholesterol screening). ▪ Annual Prostate Specific Antigen (PSA) screening. ▪ Fasting blood sugar screening (for diabetes mellitus). ▪ Annual colorectal screening. ▪ Blood pressure screening. ▪ Obesity screening and counseling. ▪ Tobacco use screening and cessation interventions. ▪ 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; sterilization; 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/**	
Routine Well Child Care (Birth through age 17)	100% of covered expenses; not subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
	Includes Office Visit charges, immunizations, laboratory blood tests, developmental screening, behavioral assessments, routine vision screening & hearing screening for newborns. **A complete list of covered ACA mandated routine services for children is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/**	
Transplant Benefit	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.
All Other Covered Medical Expenses	100% of covered expenses; subject to Calendar Year deductible.	100% of covered expenses; subject to Calendar Year deductible.

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

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