## ALLY BUILDING SOLUTIONS HEALTH BENEFIT PLAN Medical Schedule of Benefits

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

Medical Benefits	Cigna PPO Network Providers	Non-PPO Providers	
Member Benefit Year Deductible	\$500 per individual \$1,000 per family (accumulative)		
Benefit Year begins December 1st and ends November 30th of the next year.	The Benefit Year deductible does NOT include Medical Plan Co-payments or Prescription Drug Co-payments, pre-certification penalties, non-covered expenses or charges in excess of Reasonable & Customary charges.		
Plan Coinsurance	Plan pays 80% of covered expenses	Plan pays 70% of covered Reasonable & Customary charges	
Member Out-of-Pocket Maximum	\$3,000 per individual \$6,000 per family (accumulative)	Unlimited	
	Out-of-Pocket Maximum includes Medical Plan, Prescription Drug Co-payments and Coinsurance. Pre-certification penalties, non-covered expenses and charges in excess of Reasonable & Customary charges DO NOT apply toward the Out-of-Pocket Maximum.		
Lifetime Maximum Benefit	Unlimi	ited	
Alcohol & Substance Abuse Treatment	Inpatient / Partial Hospitalization: 80% Coinsurance; subject to Benefit Year deductible.	Inpatient / Partial Hospitalization: 70% Coinsurance; subject to Benefit Year deductible.	
Inpatient confinement requires Pre-certification	Outpatient Services: 100% of covered expenses following a \$40 Co-payment; not subject to Benefit Year deductible.	Outpatient Services: \$40 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
Allergy Testing & Injections	Allergy Testing & Injections: 100% of covered expenses following a \$20 Co-payment per visit; not subject to Benefit Year deductible.	Allergy Testing & Injections: \$20 Co-payment per visit then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
	Allergy Serum: 100% of covered expenses following a \$100 Co-payment; not subject to Benefit Year deductible.	Allergy Serum: \$100 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
Ambulance Services	100% of covered expenses following a \$100 Co-payment; not subject to Benefit Year deductible.	\$100 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
Chiropractic Services / Spinal Manipulation	100% of covered expenses following a \$40 Co-payment per therapy session; not subject to Benefit Year deductible.	\$40 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
	Benefit Year maximum of 35 visits; accumulates toward Outpatient Therapy Services maximum.		
Durable Medical Equipment & Supplies	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.	
Emergency Room Services	100% of covered expenses following a \$250 Co-payment for expenses charged by the Emergency Room; not subject to Benefit Year deductible. Co-payment will be waived if admitted to a Hospital directly from the Emergency Room.		
Extended Care Facility	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.	
Requires Pre-certification	Extended Care Facility includes Rehabilitation Hospital & Skilled Nursing Facility services. Benefit Year maximum of 60 days.		
Home Health Care	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.	
	Benefit Year maximum of 20 visits.		
Hospice Care Requires Pre-certification	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.	
Inpatient Hospital Services Includes Physician Services; Requires Pre-certification	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.	
Maternity Care	Initial Maternity Office Visit / Pre-natal Care: 100% of covered expenses following a \$40 Co-payment per visit; not subject to Benefit Year deductible.	Initial Maternity Office Visit / Pre-natal Care: \$40 Co-payment per visit then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
	Delivery and all Inpatient Hospital Services: 80% Coinsurance; subject to Benefit Year deductible.	<b>Delivery and all Inpatient Hospital Services:</b> 70% Coinsurance; subject to Benefit Year deductible.	

Implement confinement requires Pre-certification Pre-certification Pre-certificatin Pre-certification Pre-certification	Medical Benefits	Cigna PPO Network Providers	Non-PPO Providers	
Outpatient Imaging / X-Rays         Diagnostic Imaging / X-Rays (not complex)           Services         Independent Imaging Facility: 100% of covered expenses following a \$35 Co-payment; not subject to Elenefit Year deductible.         Independent Imaging Facility: 235 Co-payment then covered at 70%. Coinsurance; subject to Benefit Year deductible.         Corpatient Hospital: 70% Coinsurance; subject to Benefit Year deductible.         Outpatient Hospital: 70% Coinsurance; subject to Benefit Year deductible.         Outpatient Hospital: 70% Coinsurance; not subject to Benefit Year deductible.         So Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.         So Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.         So Co-payment rot subjec	Inpatient confinement requires	80% Coinsurance; subject to Benefit Year deductible. <b>Outpatient Services:</b> 100% of covered expenses following a \$40 Co-payment; not subject to	70% Coinsurance; subject to Benefit Year deductible. <b>Outpatient Services:</b> \$40 Co-payment then covered at 70% Coinsurance; not subject to	
Services         Independent Imaging Facility: 035 co-payment then covered at 70% Coinsurance, not subject to Calendar Year deductible. Outpatient Hospital: 80% Coinsurance, subject to Calendar Year deductible.         Independent Imaging Facility: 335 Co-payment then covered at 70% Coinsurance, not subject to Cenenti Year deductible.           Independent Imaging Facility: 00% of covered expenses following a 53 Co-payment; not subject to Cenenti Year deductible.         Outpatient Hospital: 70% Coinsurance subject to Cenenti Year deductible.           Independent Imaging Facility: 00% of covered expenses following a 53 Co-payment; not subject to Calendar Year deductible.         Independent Imaging Facility: 335 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.           Outpatient Laboratory Sorvices         Independent Imaging Facility: 335 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.           Outpatient Laboratory Sorvices         Independent Clinical Laboratory; 10% of covered expenses following a s35 Co-payment inten covered at 70%. Coinsurance; subject to Benefit Year deductible.           Outpatient Physician Office Visit Sorvices         Independent Clinics: 200 Co-payment not subject to Benefit Year deductible.           Primary Care Physical Office Visit Coinsurance; not subject to Benefit Year deductible.         • Primary Care Physical Office Visit Coinsurance; not subject to Benefit Year deductible.           Specialist Office Visit Sorvices Formula Visit Borcites performed inte Physical soffice.         • Primary Care Physical Oco-payment not subject to Benefit Year deductible.         • Primary Care Physicano subject to Benefit Year	Outpatient Imaging / X-Ray			
Subject to Benefit Year deductible.         Outpatient Hospital: 70% Coinsurance: subject to Benefit Year deductible.           Independent Imaging Facility: 100% of covered expenses following a S35 Co-payment; not subject to Benefit Year deductible.         Independent Imaging Facility: 353           Outpatient Laboratory Services         Independent Clinical Laboratory: 100% of covered expenses following a S35 Co-payment then covered at 70% Coinsurance subject to Benefit Year deductible.         Independent Imaging Facility: 353           Outpatient Laboratory Services         Independent Clinical Laboratory: 100% of covered expenses following a S35 Co-payment, not subject to Benefit Year deductible.         S36 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.           Outpatient Hospital: 70% Coinsurance is ubject to Benefit Year deductible.         Uitpatient Hospital: 70% Coinsurance subject to Benefit Year deductible.         Outpatient Hospital: 70% Coinsurance; not subject to Benefit Year deductible.           Outpatient Surgery performed outside of a Physician office.         • Faladoc Physician Office Visit / Convenience Care Clinic: 100% of covered expenses following a S40 Co-payment; not subject to Benefit Year deductible.         • Primary Care Physician Office Visit / Convenience Care Provider: 100% of covered expenses following a S40 Co-payment; not subject to Benefit Year deductible.         • Urgent Care Provider: 100% of covered expenses following a S40 Co-payment; not subject to Benefit Year deductible.         • Urgent Care Provider: 100% of covered expenses following a S40 Co-payment; not subject to Benefit Year deductible.         • Urgent Care Provider: 100% of covered expenses following		Independent Imaging Facility: 100% of covered expenses following a \$35 Co-payment; not subject to Calendar Year deductible.	Independent Imaging Facility: \$35 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year	
(Includes but is not limited to CT scans, MRI's, MRA's, PET scans and nuclear cardiology in a location, including the Physician's office)         Independent Imaging Facility: 100% of covered expenses following a \$35 Co-payment then covered at 70% Coinsurance; subject to Benefit Year deductible.         Independent Imaging Facility: 355 Co-payment then covered at 70% Coinsurance; subject to Benefit Year deductible.         Outpatient Hospital: 70% Coinsurance; subject to Benefit Year deductible.         Independent Clinical Laboratory: 100% of covered expenses following a \$35 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.         Outpatient Hospital: 70% Coinsurance; subject           Outpatient Physician Office Visit Corpayment in to subject to Benefit Year deductible.         Independent Clinical Laboratory: 100% of covered expenses following a \$30 Co-payment in covered at 70% Coinsurance; not subject to Benefit Year deductible.         Outpatient Hospital: 70% Coinsurance; not subject to Benefit Year deductible.           Standark X-ray, minor surgical procedures, laboratory and diagnostic services performed outside of a Physician's office Visit 100% of covered expenses following a \$40 Co-payment; not subject to Benefit Year deductible.         Primary Care Physician Coffice Visit is 40 Co-payment; not subject to Benefit Year deductible.         Urgent Care Provider: \$40 Co-payment; not subject to Benefit Year deductible.         Urgent Care Provider: \$40 Co-payment; not subject to Benefit Year deductible.         Urgent Care Provider: \$40 Co-payment; not subject to Benefit Year deductible.         Urgent Care Provider: \$40 Co-payment; not subject to Benefit Year deductible.         Urgent Care Provider: \$40 Co-payment; not subject to Benefit Year deductible.         Urgent		subject to Benefit Year deductible.		
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to Benefit Year deductible.         subject to Benefit Year deductible.           Outpatient Physician Office Visit Services         • Teladoc Physician Consultation: 100% of eligible expenses, Co-payment waived.         • Primary Care Physician Office Visit / Convenience Care Clinic: 100% of covered expenses following a \$20 Co-payment; not subject to Benefit Year deductible.         • Specialist Office Visit : 400 Co-payment; not subject to Benefit Year deductible.           Refer to Outpatient Surgery benefit for surgical procedures, laboratory and diagnostic ervices performed outside of a Physicians office.         • Urgent Care Provider: 100% of covered expenses following a \$40 Co-payment; not subject to Benefit Year deductible.         • Urgent Care Provider: \$40 Co-payment; not subject to Benefit Year deductible.           • Urgent Care Provider: 100% of covered expenses following a \$40 Co-payment; not subject to Benefit Year deductible.         • Urgent Care Provider: \$40 Co-payment; not subject to Benefit Year deductible.           Outpatient Surgery         80% Coinsurance; subject to Benefit Year deductible.         • Urgent Care Provider: \$40 Co-payment; not subject to Benefit Year deductible.           Outpatient Therapy Services         100% of covered expenses following \$40 Co-pay; not subject to Benefit Year deductible.         \$40 Co-pay then covered at 70% Coinsurance; not subject to Benefit Year deductible.           Pre-certification for Inpatient Hospital Admissions         • Pre-admission certification is mandeatory for all inpatient Hospital Admissions. Erailure to comply will result in a \$250 reduction of benefits due to pre-certification non-compliar Prescription Drug Benefits • Formulary Brand medications		100% of covered expenses following a \$35 Co-payment; not subject to Benefit Year deductible.	\$35 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
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Refer to Outpatient Surgery benefit for surgical procedures performed outside of a Physicians office.       • Urgent Care Provider: 100% of covered expenses following a \$40 Co-payment; not subject to Benefit Year deductible.       then covered at 70% Coinsurance; not subject to Benefit Year deductible.         Outpatient Surgery       Refer to Outpatient Laboratory Services benefit and Outpatient Imaging / X-Ray Services benefit treatment rendered outside of the Physicians office and for CT scans, MRI's, MRA's and PET sc in any location, including the Physician's office.         Outpatient Therapy Services       80% Coinsurance; subject to Benefit Year deductible.       70% Coinsurance; subject to Benefit Year deductible.         Outpatient Therapy Services       100% of covered expenses following \$40 Co-pay; not subject to Benefit Year deductible.       \$40 Co-pay then covered at 70% Coinsurance; not subject to Benefit Year deductible.         Pre-certification for Inpatient Hospital Admissions       Pre-admission certification is mandatory for all inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a \$250 reduction of benefits due to pre-certification non-complian (30 day supply maximum)         • Mail Order Prescriptions (90 day supply maximum)       • Generic medications: \$0; No Co-pay applies • Formulary Brand medications: \$00 No Co pay* • Non-Formulary Brand medications: \$00 No Co pay* • Non-Formulary Brand medications: \$00 No Co pay* • Non-Participating Pharmacies are not eligned to the power with the Dire	procedures, laboratory and diagnostic services performed in the Physician's office during the	<ul> <li>not subject to Benefit Year deductible.</li> <li>Specialist Office Visit: 100% of covered expenses following a \$40 Co-payment;</li> </ul>	subject to Benefit Year deductible.	
Refer to Outpatient Laboratory Services benefit and Outpatient Imaging / X-Ray Services benefit treatment rendered outside of the Physicians office and for CT scans, MRI's, MRA's and PET sc in any location, including the Physician's office.Outpatient Surgery80% Coinsurance; subject to Benefit Year deductible.70% Coinsurance; subject to Benefit Year deductible.Outpatient Therapy Services100% of covered expenses following \$40 Co-pay; not subject to Benefit Year deductible.\$40 Co-pay then covered at 70% Coinsurance; not subject to Benefit Year deductible.Pre-certification for Inpatient Hospital AdmissionsPre-admission certification is mandatory for all inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a \$250 reduction of benefits due to pre-certification non-compliar Failure to comply will result in a \$250 reduction of benefits due to pre-certification non-compliar (30 day supply maximum)Retail Network Pharmacy Co-pay applies • Formulary Brand medications: \$30 Co-pay* • Non-Formulary Brand medications: \$60 Co-pay* • Non-Formulary Brand medications: \$60 Co-pay* • Non-Participating Pharmacies are not elign • Non Participating Pharmacies are not elign • Non-Participating Pharmacies are not elign • Non Participating Pharmacies are not elign • Non Participating Pharmacies are not elign • Non-Participating Pharmacies are not elign • Non-Participating Pharmacies are not elign • Non Participating Phar	benefit for surgical procedures performed outside of a	<ul> <li>Urgent Care Provider: 100% of covered expenses following a \$40 Co-payment;</li> </ul>	then covered at 70% Coinsurance; not	
Subject to Benefit Year deductible.         Subject to Benefit Year deductible.           Outpatient Therapy Services         100% of covered expenses following \$40 Co-pay; not subject to Benefit Year deductible.         \$40 Co-pay then covered at 70% Coinsura not subject to Benefit Year deductible.           Combined Benefit Year maximum of 35 visits for all rehabilitative therapy including Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Treatment.           Pre-certification for Inpatient Hospital Admissions         Pre-admission certification is mandatory for all inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a \$250 reduction of benefits due to pre-certification non-complian Generic medications: \$0; No Co-pay applies Formulary Brand medications: \$30 Co-pay* Non-Formulary Brand medications: \$30 Co-pay* Non-Formulary Brand medications: \$60 Co-pay* Non-Formulary Brand medications: \$0; No Co-payments: Control medications: \$0; No Co-payments: Mail Order Prescription Co-payments: (90 day supply maximum)         Prescription Co-payments: Mail Order Prescription Co-payments: Control medications: \$0; No Co-payments: Non-Formulary Brand medications: \$0; No Co-pay applies Formulary Brand medications: \$0; No Co-pay applies Formulary Brand medications: \$0; No Co-pay* Non-Participating Pharmacies are not elige Non-Participating Pharmacies are not elige for minup Pharmacies are not elige for minup Pharmacies are not elige		Refer to Outpatient Laboratory Services benefit and Outpatient Imaging / X-Ray Services benefit treatment rendered outside of the Physicians office and for CT scans, MRI's, MRA's and PET sc		
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Pre-certification for Inpatient Hospital Admissions       Pre-admission certification is mandatory for all inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a \$250 reduction of benefits due to pre-certification non-compliant Failure to comply will result in a \$250 reduction of benefits due to pre-certification non-compliant Generic medications: \$0; No Co-pay applies         • Retail Prescriptions (30 day supply maximum)       • Generic medications: \$0; No Co-pay applies         • Mail Order Prescriptions (90 day supply maximum)       • Non-Formulary Brand medications: \$60 Co-pay*         • Mail Order Prescriptions (90 day supply maximum)       • Mail Order Prescription Co-payments: Operation medications: \$0; No Co-pay applies	Outpatient Therapy Services		\$40 Co-pay then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
Hospital Admissions       Emergency hospital admissions must be approved within 48 hours.         Failure to comply will result in a \$250 reduction of benefits due to pre-certification non-compliant         Prescription Drug Benefits       Retail Network Pharmacy Co-payments:         • Retail Prescriptions (30 day supply maximum)       • Generic medications: \$0; No Co-pay applies         • Formulary Brand medications: \$30 Co-pay*       • Non-Formulary Brand medications: \$60 Co-pay*         • Mail Order Prescriptions (90 day supply maximum)       • Mail Order Prescription Co-payments:				
<ul> <li>Retail Prescriptions (30 day supply maximum)</li> <li>Mail Order Prescriptions (90 day supply maximum)</li> <li>Generic medications: \$0; No Co-pay applies</li> <li>Formulary Brand medications: \$30 Co-pay*</li> <li>Non-Formulary Brand medications: \$60 Co-pay*</li> <li>Prescription drugs purchased from Mail Order Prescription Co-payments: Non-Participating Pharmacies are not eliging</li> </ul>		Pre-admission certification is mandatory for all inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a \$250 reduction of benefits due to pre-certification non-compliance.		
<ul> <li>(30 day supply maximum)</li> <li>Mail Order Prescriptions (90 day supply maximum)</li> <li>Formulary Brand medications: \$30 Co-pay*</li> <li>Non-Formulary Brand medications: \$60 Co-pay*</li> <li>Prescription drugs purchased from Mail Order Prescription Co-payments:</li> <li>Non-Participating Pharmacies are not eligned</li> </ul>	Prescription Drug Benefits			
(90 day supply maximum) Mail Order Prescription Co-payments: Non-Participating Pharmacies are not elig	(30 day supply maximum)	Formulary Brand medications: \$30 Co-pay*		
The second se	(90 day supply maximum)		Prescription drugs purchased from Non-Participating Pharmacies are not eligible for reimbursement by the Plan.	
<ul> <li>* If a Generic drug is available and a Brand drug is purchased, the covered member will pay the Brand Co-pay plus the difference in cost between the generic and</li> <li>* Generic medications: \$0, No Co-pay applies</li> <li>* Formulary Brand medications: \$60 Co-pay*</li> <li>* Non-Formulary Brand medications: \$120 Co-pay*</li> <li>* Specialty / Injectible Prescription Co-pay: Co-payments listed above shall apply</li> </ul>	and a Brand drug is purchased, the covered member will pay the Brand Co-pay plus the difference	<ul> <li>Formulary Brand medications: \$60 Co-pay*</li> <li>Non-Formulary Brand medications: \$120 Co-pay*</li> <li>Specialty / Injectible Prescription Co-pay:</li> </ul>		

Medical Benefits	Cigna PPO Network Providers	Non-PPO Providers	
Prosthetic Appliances	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.	
Routine Colonoscopy	100% of covered expenses; not subject to Benefit Year deductible. Age and frequency schedule apply.		
Routine Mammogram	100% of covered expenses; not subject to Benefit Year deductible. Age and frequency schedule apply.		
Routine Well Adult Care	100% of covered expenses; not subject to Benefit Year deductible.		
(Age 18 and above)	<ul> <li>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:</li> <li>Immunizations.</li> <li>Fasting lipoprotein profile (cholesterol screening).</li> <li>Annual Prostate Specific Antigen (PSA) screening.</li> <li>Fasting blood sugar screening (for diabetes mellitus).</li> <li>Annual colorectal screening.</li> <li>Bone Mineral Density (BMD) screening (once every 24 months).</li> <li>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.</li> <li>A complete list of covered ACA mandated routine services for women / adults is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/</li> </ul>		
Routine Well Child Care (Birth through age 17)	100% of covered expenses; not subject to Benefit 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	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.	
Vision - Annual Eye Exam	100% of covered expenses following a \$40 Co-payment; not subject to Benefit Year deductible.	\$40 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.	
All Other Covered Medical Expenses	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.	

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

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

www.PreferredTPA.com

BENEFIT ADMINISTRATORS INCORPORATED