ALLY BUILDING SOLUTIONS HEALTH BENEFIT PLAN **PPO Plan: $2500 Deductible**
Medical Schedule of Benefits **Effective December 1, 2021**

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 Benefit Year begins December 1st and ends November 30th of the next year.	$2,500 per individual $5,000 per family (accumulative)	
	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.	
Coinsurance	Plan pays 80% of covered expenses	Plan pays 70% of covered Reasonable & Customary charges
Member Out-of-Pocket Maximum	$4,000 per individual $8,000 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	Unlimited	
Alcohol & Substance Abuse Treatment Inpatient confinement requires Pre-certification	**Inpatient / Partial Hospitalization:** 80% Coinsurance; subject to Benefit Year deductible. **Outpatient Services:** 100% of covered expenses following a $40 Co-payment; not subject to Benefit Year deductible.	**Inpatient / Partial Hospitalization:** 70% Coinsurance; 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 Serum:** 100% of covered expenses following a $100 Co-payment; 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 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 Requires Pre-certification	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.
	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. **Delivery and all Inpatient Hospital Services:** 80% Coinsurance; 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:** 70% Coinsurance; subject to Benefit Year deductible.

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Mental Health Services Inpatient confinement requires Pre-certification	**Inpatient / Partial Hospitalization:** 80% Coinsurance; subject to Benefit Year deductible. **Outpatient Services:** 100% of covered expenses following a $40 Co-payment; not subject to Benefit Year deductible.	**Inpatient / Partial Hospitalization:** 70% Coinsurance; subject to Benefit Year deductible. **Outpatient Services:** $40 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.
Outpatient Imaging / X-Ray Services	**Diagnostic Imaging / X-Rays (not complex):** (Outpatient Hospital or another outpatient facility)	
	Independent Imaging Facility: 100% of covered expenses following a $35 Co-payment; not subject to Calendar Year deductible. **Outpatient Hospital:** 80% Coinsurance; subject to Benefit Year deductible.	**Independent Imaging Facility:** $35 Co-pay then covered at 70% Coinsurance; not subject to Benefit Year deductible. **Outpatient Hospital:** 70% Coinsurance; subject to Benefit 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)	
	Independent Imaging Facility: 100% of covered expenses following a $35 Co-payment; not subject to Calendar Year deductible. **Outpatient Hospital:** 80% Coinsurance; subject to Benefit Year deductible.	**Independent Imaging Facility:** $35 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible. **Outpatient Hospital:** 70% Coinsurance; subject to Benefit Year deductible.
Outpatient Laboratory Services	**Independent Clinical Laboratory:** 100% of covered expenses following a $35 Co-payment; not subject to Benefit Year deductible. **Outpatient Hospital:** 80% Coinsurance; subject to Benefit Year deductible.	**Independent Clinical Laboratory:** $35 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible. **Outpatient Hospital:** 70% Coinsurance; subject to Benefit 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.	▪ **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:** 100% of covered expenses following a $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.	▪ **Primary Care Physician Office Visit / Convenience Care Clinic:** $20 Co-pay then covered at 70% Coinsurance; not subject to Benefit Year deductible. ▪ **Specialist Office Visit:** $40 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible. ▪ **Urgent Care Provider:** $40 Co-payment then covered at 70% Coinsurance; not subject to Benefit 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	80% Coinsurance; subject to Benefit Year deductible.	70% Coinsurance; subject to Benefit Year deductible.
Outpatient Therapy Services	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.
	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-compliance.	
Prescription Drug Benefits ▪ Retail Prescriptions (30 day supply maximum) ▪ Mail Order Prescriptions (90 day supply maximum) *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 the brand name drug.	**Retail Network Pharmacy Co-payments:** ▪ Generic medications: $0; No Co-pay applies ▪ Formulary Brand medications: $30 Co-pay* ▪ Non-Formulary Brand medications: $60 Co-pay* **Mail Order Prescription Co-payments:** ▪ Generic medications: $0; No Co-pay applies ▪ Formulary Brand medications: $60 Co-pay* ▪ Non-Formulary Brand medications: $120 Co-pay* **Specialty / Injectible Prescription Co-pay:** Co-payments listed above shall apply	Prescription drugs purchased from Non-Participating Pharmacies are not eligible for reimbursement by the Plan.

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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 (Age 18 and above)	100% of covered expenses; not subject to Benefit 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 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:

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