

ALLY BUILDING SOLUTIONS HEALTH BENEFIT PLAN
Medical Schedule of Benefits

PPO Plan: \$3500 Deductible
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.	\$3,500 per individual \$7,000 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	\$5,000 per individual \$10,000 per family (accumulative) 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.	Unlimited
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. Benefit Year maximum of 35 visits; accumulates toward Outpatient Therapy Services maximum.	\$40 Co-payment then covered at 70% Coinsurance; not subject to Benefit Year deductible.
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 other 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-payment 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.	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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-pay; not subject to Benefit Year deductible.	\$40 Co-pay 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 <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ▪ Generic medications: \$0; No Co-pay applies ▪ Formulary Brand medications: \$60 Co-pay* ▪ Non-Formulary Brand medications: \$120 Co-pay* Specialty / Injectable 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: <ul style="list-style-type: none"> Immunizations. Fasting lipoprotein profile (cholesterol screening). Annual Prostate Specific Antigen (PSA) screening. Fasting blood sugar screening (for diabetes mellitus). Annual colorectal screening. 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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