Mark Kaufman Roofing Health Benefit Plan **Effective May 1, 2020**
Medical Schedule of Benefits

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

Medical Benefits	First Health PPO Providers	Non-PPO Providers
Member Plan Year Deductible Plan Year: May 1st – April 30th	$1,500 per individual. $3,000 per family (accumulative).	$2,000 per individual. $10,000 per family (accumulative).
	Plan Year deductible does not include Co-payments. PPO and Non-PPO deductible amounts shall combine together.	
Plan Coinsurance	80% of covered expenses.	60% of covered expenses.
Member Out-of-Pocket Maximum PPO and Non-PPO Out-of-Pocket Maximums shall combine together.	$3,000 per individual. $6,000 per family (accumulative).	Non-PPO provider services do not have an Out-Of-Pocket Maximum.
	Out-of-pocket expenses include Medical & Rx Co-payments, Coinsurance and the Plan Year Deductible. Non-covered expenses and pre-certification penalties do not apply toward the Out-of-Pocket Maximum.	
Lifetime Overall Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Services	**Inpatient / Partial Hospitalization:** 80% Coinsurance; subject to Plan Year deductible.	**Inpatient / Partial Hospitalization:** 60% Coinsurance; subject to Plan Year deductible.
	Outpatient Services: 100% of eligible charges following a $40 Co-payment; not subject to Plan Year deductible.	**Outpatient Services:** 60% Coinsurance; subject to Plan Year deductible.
Allergy Injections	100% of covered expenses; not subject to the Plan Year deductible.	80% Coinsurance; subject to Plan Year deductible.
Ambulance Services	80% Coinsurance; subject to Plan Year deductible.	80% Coinsurance; subject to Plan Year deductible.
Birthing Center	80% of covered expenses; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
Chiropractic Care / Spinal Manipulation	100% of eligible charges following a $30 Co-payment; not subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
	Plan Year maximum benefit of 26 visits.	
Durable Medical Equipment	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
Emergency Room Services	100% of eligible charges following a $300 Co-payment per visit.	
Extended Care Facility	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
	Plan Year maximum benefit of 60 days. Extended Care Facility also includes Rehabilitation Hospital & Skilled Nursing Facility services.	
Home Health Care	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
	Plan Year maximum benefit of 60 visits.	
Hospice Care	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
Inpatient Hospital Services	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
Maternity Care	Initial diagnosis / office visit payable at 100% following a $30 Co-payment; not subject to Plan Year deductible. Physician obstetrical fee for all pre-natal care / delivery shall be payable at 80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
Mental Health Services	**Inpatient / Partial Hospitalization:** 80% Coinsurance; subject to Plan Year deductible.	**Inpatient / Partial Hospitalization:** 60% Coinsurance; subject to Plan Year deductible.
	Outpatient Services: 100% of eligible charges following $30 Co-payment; not subject to Plan Year deductible.	**Outpatient Services:** 60% Coinsurance; subject to Plan Year deductible.
Outpatient Diagnostic Services Includes CT Scans, PET Scans, MRI and Endoscopy	**Ambulatory Facility:** 80% Coinsurance; subject to Plan Year deductible. **Hospital based facility:** 80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.

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Outpatient Laboratory & X-Ray Services	100% of covered expenses; not subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
	For complex diagnostic services such as CT Scans, PET Scans, MRI and Endoscopy, refer to Outpatient Diagnostic Services.	
Outpatient Physician Office Visit Services Refer to Outpatient X-Ray & Laboratory benefit for services rendered outside of the Physician's office.	**Teladoc Physician Consultation:** $0 Co-payment, not subject to Plan Year deductible. **Primary Care Office Visit:** 100% of eligible charges following $30 Co-payment; not subject to Plan Year deductible. **Specialist Office Visit:** 100% of eligible charges following $60 Co-payment; not subject to Plan Year deductible. **Urgent Care Visit:** 100% of eligible charges following $75 Co-payment; not subject to Plan Year deductible.	60%Coinsurance; subject to Plan Year deductible.
	Includes office visit charges, x-ray, laboratory, diagnostic services, supplies & minor surgical procedures performed in the Physician's office during the office visit.	
Outpatient Surgery Applies to Surgery performed outside of a Physician's office.	**Ambulatory Surgical Facility:** 80% Coinsurance; subject to Plan Year deductible. **Hospital based facility:** 80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
Outpatient Therapy Services	100% of eligible charges following a $30 Co-payment; not subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible and Plan Year maximum benefit.
	Plan Year maximum benefit of 60 visits per condition. Includes Occupational Therapy, Physical Therapy and Speech Therapy.	
Podiatry Services	100% of eligible charges following a $30 Co-payment; not subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
	Plan Year maximum benefit of 25 visits.	
Pre-Admission Testing	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
Pre-Certification Requirements	Pre-admission certification for an elective non-emergency hospital admission is mandatory. Emergency admissions must be approved within 48 hours. Failure to comply result in penalty of $500.	
Prescription Drug Benefits Retail Prescriptions (30 day supply maximum) Mail Order Prescriptions (90 day supply maximum) Specialty Drugs (30 day supply maximum)	**Prescription Drug Card:** ▪ Generic drugs: $10 Co-payment ▪ Formulary Brand: $30 Co-payment* ▪ Non-Formulary Brand: $60 Co-payment* *Mandatory Generic requirement unless Medically Necessary **Mail Order Prescriptions:** ▪ Generic drugs: $20 Co-payment ▪ Formulary Brand: $60 Co-payment ▪ Non-Formulary Brand: $120 Co-payment	**Specialty Drug Program:** 100% of covered expenses following $200 Co-payment; not subject to Plan Year deductible. Note: The filling of Specialty Drugs will be coordinated through Preferred Benefit Administrators. **Important Note:** Prescriptions purchased from Non-Participating Pharmacies or outside of the Mail Order Drug Program are not eligible for reimbursement through the Plan.
Prosthetic Devices	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; not subject to Plan Year deductible.
Routine Well Adult Care (Age 17 and above)	100% of eligible charges; not subject to Plan Year deductible.	60% Coinsurance; not subject to Plan 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. ▪ Statin preventive medication ▪ 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/	

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Routine Well Child Care (Birth through age 16)	100% of eligible charges (No Co-payment applies); not subject to Plan Year deductible.	60% Coinsurance; not subject to Plan Year deductible.
	Includes, but is not limited to, Office Visit charges, immunizations, laboratory blood tests, developmental screening, behavioral assessments and 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/	
Second Surgical Opinion	100% of eligible charges following a $60 Co-payment.	60% Coinsurance; subject to Plan Year deductible.
Transplant Benefit	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.
	Refer to the Plan Document for specific information regarding this benefit.	
All Other Covered Medical Expenses	80% Coinsurance; subject to Plan Year deductible.	60% Coinsurance; subject to Plan Year deductible.

Coverage and Benefit questions should be directed to:

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