VAUGHN ELECTRIC COMPANY HEALTH BENEFIT PLAN
Medical Summary of Benefits **Effective July 1, 2022**

Refer to the Medical Plan Document and Summary Plan Description for details of Coverage.
This Plan is an open access health plan for Hospitals / Facilities that does not restrict member access based on network affiliation. All non-Hospital services should be rendered by a PHCS PPO provider to receive the highest level of Benefits.

MEDICAL BENEFITS	Hospitals / Facilities that ACCEPT Value Based Pricing & PHCS Practitioner & Ancillary Providers (PHCS Practitioner & Ancillary Only)	Hospitals / Facilities that DO NOT ACCEPT Value Based Pricing & Non-PPO Practitioner & Ancillary Providers
Member Benefit Year Deductible Benefit Year begins July 1st of each year and ends June 30th of the following year.	$2,000 per individual $4,000 per family unit	$4,000 per individual $8,000 per family unit
	Note: A family unit refers to an Employee plus one or more Dependents. If an Employee is enrolled for Family Coverage the Family deductible must be met before any claims are paid. The total Family deductible may be met by claims of one or more individuals. The Benefit Year deductible does NOT include pre-certification penalties, non-covered expenses or charges in excess of the Plan Allowable rate. Benefits do not combine for Providers that do not accept VBR / Non-PPO Providers and Providers that do accept VBP and are PHCS Providers.	
Plan Allowable	100% of Reasonable & Allowed Amount	70% of Plan Allowable
	Plan Allowable for Hospital / Facility charge is 140% of the Medicare allowable rate. Plan Allowable for all non-Hospital provider charges is 120% of Medicare allowable rate if provider is not in PHCS PPO Network. See Plan Document & Summary Plan Description for additional information.	
Member Out-of-Pocket Maximum	$6,350 per individual $12,700 per family unit	Unlimited
	Note: A family unit refers to an Employee plus one or more Dependents. If an Employee is enrolled for Family Coverage, the Family Out-of-Pocket Maximum must be met before any claims are paid. The total Family Out-of-Pocket may be met by claims of one or more individuals. Out-of-Pocket Maximum includes Benefit Year deductible. Prescription Drug Co-payments and Member Plan Allowable. Pre-certification penalties, non-covered expenses & charges in excess of the Plan Allowable rate do not apply toward the Out-of-Pocket Maximum. Benefits do not combine for Providers that do not accept VBR / Non-PPO Providers and Providers that do accept VBP and PHCS Providers.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
	Inpatient admission requires Pre-certification.	
Allergy Injections & Testing	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Ambulance Services	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	
Chiropractic Services / Spinal Manipulation	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
	Benefit Year maximum of 20 visits.	
Durable Medical Equipment & Supplies	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Emergency Room Services	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	
Extended Care Facility Includes Skilled Nursing & Rehabilitation Facility	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
	Benefit Year maximum benefit of 60 days; requires Pre-certification.	
Home Health Care	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
	Benefit Year maximum benefit of 60 days.	
Hospice Care Requires Pre-certification	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Inpatient Hospital Services Includes Physician Services	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
	Inpatient admission requires Pre-certification.	
Maternity Care	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Mental Health Services	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
	Inpatient admission requires Pre-certification.	

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Outpatient Imaging Services	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Outpatient Laboratory & X-Ray Services	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Outpatient Physician Office Visit Services	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
	Includes Convenience Care Clinic, Primary Care Office Visit, Specialist Visit & Urgent Care Provider.	
Outpatient Surgery	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Outpatient Therapy Services	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
	Benefit year maximums: Occupational Therapy - 20 visits; Physical Therapy - 20 visits; Speech Therapy - 20 visits; Pulmonary Rehabilitation Therapy - 36 visits.	
Pre-certification for Inpatient Hospital Admissions	**Pre-admission certification is mandatory for inpatient Hospital Admissions and Outpatient Facility Services.** Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a 50% reduction in benefits payable due to pre-certification non-compliance.	
Prescription Drug Benefits ▪ Retail Prescriptions (30 day supply maximum) ▪ Mail Order Prescriptions (90 day supply maximum)	**Prescription Drug Co-payments apply after Benefit Year Deductible has been satisfied** **Retail Network Pharmacy Co-payments:** ▪ Generic drugs: $10.00 ▪ Preferred Brand drugs: $50.00 ▪ Non-Preferred Brand drugs: $80.00 **Mail Order Prescription Co-payments:** ▪ Generic drugs: $30.00 ▪ Preferred Brand drugs: $150.00 ▪ Non-Preferred Brand drugs: $240.00	**Specialty / Injectible Prescription Co-pay:** 25% Co-pay up to $500 per Prescription. Some Specialty Rx's may be available with a $0 Co-pay. Contact Preferred Benefit Admin. to see if your Rx qualifies. Prescriptions purchased from Non-Participating Pharmacies are not eligible for reimbursement by the Plan.
Prosthetic Appliances	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Routine Colonoscopy (Age 45+)	100% of Reasonable & Allowed Amount; not subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Routine Mammogram (Age 40+)	100% of Reasonable & Allowed Amount; not subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
Routine Well Adult Care (Age 18 and above)	100% of Reasonable & Allowed Amount; not subject to Benefit Year deductible.	70% of Plan Allowable; 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 (age 45+). ▪ 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/**	
Routine Well Child Care (Birth through age 17)	100% of Reasonable & Allowed Amount; not subject to Benefit Year deductible.	70% of Plan Allowable; 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	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.
All Other Covered Medical Expenses	100% of Reasonable & Allowed Amount; subject to Benefit Year deductible.	70% of Plan Allowable; subject to Benefit Year deductible.

Questions regarding Coverage / Benefits should be directed to:

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

Preferred BENEFIT ADMINISTRATORS INCORPORATED

To locate PHCS Practitioner & Ancillary Providers visit www.multiplan.com/phcspracanc or call (877)952-7427

PHCS Practitioner & Ancillary Only