Summary of Medical Benefits

Online Access, Inc.

Effective 12/1/22

HSA PPO Plan

This schedule is provided as a convenience only and is not all-inclusive.

This Plan may have other requirements and provisions that may affect benefits that are not listed within this schedule. It is strongly recommended that you read the plan's entire Summary Plan Description (SPD) to ensure a complete understanding of the Plan provisions and coverages.

Note: If you receive care from a **non-network provider**, even when referred, you may be billed for the difference between the Plan's approved amount and the provider's charge

Timely Claim Filing: to be eligible for reimbursement under the Plan, your provider must submit the claim within 90 days from the date of service. Claims filed after that time may be denied.

Precertification is required at least 2 weeks prior to all inpatient hospital admissions, most outpatient procedures & high-tech imaging. Certification is required within 48 hours after an emergency admission/treatment.

	In-Network	Out-of-Network
Annual Deductible (applies to expenses below unless otherwise noted)	$1,400 / single contract $2,800 / 2 person or family contract	$2,800 / single contract $5,600 / 2 person or family contract
Annual Coinsurance (applies to expenses below unless otherwise noted	$1,000 / single contract $2,000 / 2 person or family contract	$2,000 / single contract $4,000 / 2 person or family contract
Annual Out-of-Pocket Maximum (includes covered expenses under the Plan)	$2,400 / single contract $4,800 / 2 person or family contract	$4,800 / single contract $9,600 / 2 person or family contract

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Allergy Testing, Serum, and Treatment	Plan pays 80%	Plan pays 60%
Allergy Shots	Plan pays 80%	Plan pays 60%
Ambulance Service	Plan pays 80%	Plan pays 60% (emergency services paid at in-network level)
Ambulatory Surgical Center	Plan pays 80%	Plan pays 60%
Anesthetics, Oxygen, Transfusions	Plan pays 80%	Plan pays 60%
Chemotherapy	Plan pays 80%	Plan pays 60%
Chiropractic Care Limited to 24 visits per calendar year	Plan pays 80%	Plan pays 60%
Diagnostic X-rays and Lab Services (includes advanced radiological imaging)		
Performed in and billed by a physician's office	Plan pays 80%	Plan pays 60%
Performed in and billed by an outside lab/facility	Plan pays 80%	Plan pays 60%
Pre-admission Testing (performed prior to a hospital confinement)	Plan pays 80%	Plan pays 60%
Durable Medical Equipment	Plan pays 80%	Plan pays 60%
Emergency/Acute Care Hospital ER Room	Plan pays 80%	Plan pays 80%
Acute Care Facility	Plan pays 80%	Plan pays 60%
Hemodialysis	Plan pays 80%	Plan pays 60%
Home Health Care	Plan pays 80%	Plan pays 60%
Hospice Care Precertification required.	Plan pays 80%	Plan pays 60%
Hospital Services – Inpatient	Plan pays 80%	Plan pays 60%
Hospital Services – Outpatient	Plan pays 80%	Plan pays 60%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Infertility Treatment (includes services for the diagnosis of infertility only)	Plan pays 80%	Plan pays 60%
Maternity Benefits – includes physician services for prenatal visits and routine pre- and post-partum care, childbirth and pregnancy-related conditions		
Inpatient hospital services or birthing center including labor and delivery (requires precertification)	Plan pays 80%	Plan pays 60%
Medical Supplies (covered under Durable Medical Equipment above)	Plan pays 80%	Plan pays 60%
Mental Health and Substance Abuse Treatment		
Doctor's office visits or Outpatient/Intermediate Care	Plan pays 80%	Plan pays 60%
Inpatient Care (requires precertification)	Plan pays 80%	Plan pays 60%
Newborn Care – Inpatient	Plan pays 80%	Plan pays 60%
Organ Transplants – See description of coverage and limitations below Precertification required.	Plan pays 80%	Plan pays 60%
Private Duty Nursing	Plan pays 80%	Plan pays 60%
Primary Care Physician - Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies)	Plan pays 80%	Plan pays 60%
Specialist Physician – Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies)	Plan pays 80%	Plan pays 60%
Prosthetics	Plan pays 80%	Plan pays 60%
Radiation Therapy	Plan pays 80%	Plan pays 60%
Reconstructive Surgery Precertification required.	Plan pays 80%	Plan pays 60%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Routine Preventive Care/Wellness Benefits (Deductible does not apply In-Network)		
Routine periodic and screening exams	Plan pays 100%	Not Covered
Women's Preventive Services	Plan pays 100%	Not Covered
Well-baby/Well-child Care	Plan pays 100%	Not Covered
Immunizations	Plan pays 100%	Not Covered
Routine Patient Costs relating to Approved Clinical Trials	Plan pays 80%	Plan pays 60%
Second Surgical Opinions – voluntary	Plan pays 80%	Plan pays 60%
Second Procedure/Surgical Opinions (Deductible does not apply In-Network)	Plan pays 100%	Plan pays 100%
Skilled Nursing Facility Limit of 90 days per calendar year (combined in- and out-of-network) Precertification required.	Plan pays 80%	Plan pays 60%
Sterilization Procedures	Plan pays 80%	Plan pays 60%
Surgery * Precertification required.		
Hospital Inpatient * Precertification required.	Plan pays 80%	Plan pays 60%
***Outpatient Facility** Precertification required.	Plan pays 80%	Plan pays 60%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Therapy Services		
Cardiac Rehabilitation Therapy		
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Excludes habilitative therapy treatment to help keep, learn or improve skills and functioning (versus rehabilitative therapy following an illness/injury)		
Therapy limited to combined maximum visits of 60 per plan year for:		
Occupational, physical, speech (combined in- and out-of-network)		
Performed in and billed by Physician's office	Plan pays 80%	Plan pays 60%
Performed at outpatient facility or inpatient	Plan pays 80%	Plan pays 60%

	Your Prescription Drug Coverage	
EHM Pharmacy Benefits Managed	In-Network Retail Pharmacy (up to a 30-day supply)	Mail-Service Program (up to a 90-day supply)
	Co-Pay	Co-Pay
Generic	$10 after deductible	$20 after deductible
Preferred Brand Name	$40 after deductible	$80 after deductible
Non-Preferred Brand Name	Not Covered	Not Covered
Specialty Medications	Not Covered	Not Covered

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please contact your employer's Human Resources Department. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary in your Summary Plan Description provided by your employer.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,400/Individual or $2,800/family Out-of-Network: $2,800 individual /$5,600 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,400 individual / $4,800 family; for out-of-network providers $4,800 individual / $9,600 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	premiums, balance-billing charges, health care this plan doesn't cover and out-of-network services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cofinity.net or call 1-800-831-1166 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	No coverage	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ehimrx.com	Generic drugs (Tier 1)	$10 copay/prescription retail, $20 copay/ prescription mail order	No coverage	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$40 copay/prescription retail, $80 copay/ prescription mail order	No coverage	
	Non-preferred brand drugs (Tier 3)	No coverage	No coverage	
	Specialty drugs (Tier 4)	No coverage	No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	For emergency room care, must be a medical emergency, see your Summary Plan Description (SPD) for more details.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	For inpatient, precertification required.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No charge	40% coinsurance	Preauthorization is required for delivery services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Check with plan for limitations that may apply based on type of therapy. Limited to combined 60 visits/calendar year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	No coverage	No coverage	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required. Limited to 90 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No charge	No charge	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No coverage	No coverage	Coverage not part of medical plan
	Children's glasses	No coverage	No coverage	Coverage not part of medical plan
	Children's dental check-up	No coverage	No coverage	Coverage not part of medical plan

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Weight Loss Programs
- Routine Foot Care
- Routine eye care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Infertility Treatment (diagnosis only) • Private Duty Nursing • Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies would be your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov
Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,400**
Specialist copayment	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$2,550**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,400**
Specialist copayment	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,400
Copayments	$360
Coinsurance	$310
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$2,150**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,400**
Specialist copayment	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,400
Copayments	$0
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,520**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.