



**SCHEDULE OF BENEFITS**  
**HDHP**  
(All active employees EXCEPT Transit Union)

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in your Summary Plan Description. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read the entire summary plan description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

<b>Your Responsibilities</b>	<b>In network</b>	<b>Out of network</b>
<b>Deductible*</b>	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family
<b>Coinsurance*</b>	10%	30%
<b>Annual Coinsurance Limit</b>	\$1,000 individual \$2,000 family	\$2,500 individual \$5,000 family
<b>Annual Deductible and Coinsurance Limit</b>	\$2,500 individual \$5,000 family	\$5,000 individual \$10,000 family
<b>Out of Pocket Maximum</b> (Deductible, coinsurance, and medical copayments)  In-network amounts accumulate to the out-of-network out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	\$6,400 individual \$12,900 family  The individual in-network out of pocket is limited to \$6,400 when enrolled in a family plan.	\$8,900 individual \$17,900 family
* The family deductible and coinsurance can be satisfied by <b>one</b> family member. The deductible must be satisfied before the plan will make any payment for services (other than preventive services).		

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Ambulance services</b>	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
<b>Anesthesia services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Autism services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Chiropractic Services</b> (Includes chiropractic office visit. No coverage for maintenance therapy.)	Subject to deductible and coinsurance	Subject to deductible and coinsurance



Your Benefits	In network	Out of network
<b>Durable medical equipment and medical supplies</b> (Including insulin pump and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hearing aids and implantable hearing devices</b> (Limited to children up to age 18)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hearing examinations</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Home health care</b> (Limited to 100 visits per 12 month period)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospice care</b> <ul style="list-style-type: none"> <li>• <b>Home hospice</b> (Limited to 80 visits per 6 month period)</li> <li>• <b>Inpatient hospice</b> (Limited to 30 days per calendar year)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital emergency room services**</b> <ul style="list-style-type: none"> <li>• <b>Emergency room facility</b></li> <li>• <b>Other emergency room services</b></li> </ul>	Subject to deductible until satisfied, then subject to 10% coinsurance after \$100 copayment	Subject to in-network deductible until satisfied, then subject to 10% coinsurance after \$100 copayment
<b>Hospital inpatient services**</b> (Including semi-private or special care room, operating room, ancillary services and supplies. Precertification required.)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital outpatient and surgical center services</b> (Not including emergency room)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Maternity services</b> <ul style="list-style-type: none"> <li>• <b>Hospital services</b></li> <li>• <b>Physician services</b></li> <li>• <b>Breast pump</b></li> <li>• <b>Breast feeding support / supplies, counseling</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance



Your Benefits	In network	Out of network
<b>Mental health and substance abuse services</b> <ul style="list-style-type: none"> <li><b>Inpatient care**</b> (Pre-certification required)</li> <li><b>Outpatient care</b></li> <li><b>Transitional care</b></li> </ul>	Subject to deductible and coinsurance  Subject to deductible and coinsurance  Subject to deductible and coinsurance	Subject to deductible and coinsurance  Subject to deductible and coinsurance  Subject to deductible and coinsurance
<b>Office visit</b> (Includes chiropractic office visit)	Subject to deductible and coinsurance	Subject to deductible and Coinsurance
<b>Outpatient laboratory Services</b>	Subject to deductible and coinsurance	Subject to deductible and Coinsurance
<b>Outpatient radiology Services</b>	Subject to deductible and coinsurance	Subject to deductible and Coinsurance
<b>Outpatient therapy services</b> <ul style="list-style-type: none"> <li><b>Occupational therapy</b> (Precertification required after 15 visits)</li> <li><b>Physical therapy</b> (Precertification required after 15 visits)</li> <li><b>Speech therapy</b> (Precertification required after 15 visits)</li> </ul>	Subject to deductible and coinsurance  Subject to deductible and Coinsurance  Subject to deductible and coinsurance	Subject to deductible and coinsurance  Subject to deductible and coinsurance  Subject to deductible and coinsurance
<b>Physician services</b> <ul style="list-style-type: none"> <li><b>Hospital services</b></li> <li><b>Other services in an office</b></li> </ul>	Subject to deductible and coinsurance  Subject to deductible and coinsurance	Subject to deductible and coinsurance  Subject to deductible and coinsurance
<b>Preventive benefit</b> <ul style="list-style-type: none"> <li><b>Comprehensive physical examination</b> (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care</li> <li><b>Gynecological examination for women</b> (breast exam and pelvic exam)</li> <li><b>Digital prostate examination</b></li> </ul>	Covered at 100%  1 per calendar year then subject to deductible and coinsurance  1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance  Subject to deductible and coinsurance  Subject to deductible and Coinsurance



Your Benefits	In network	Out of network
<b>Preventive benefit (cont.)</b> <ul style="list-style-type: none"> <li>• <b>Comprehensive preventive vision examination</b></li> <li>• <b>Mammogram to screen for breast cancer</b> (includes 3D mammogram)</li> <li>• <b>Pap smear to screen for cervical cancer</b></li> <li>• <b>Colonoscopy screening for colorectal cancer</b></li> <li>• <b>Other screenings for colorectal cancer</b> ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing</li> <li>• <b>Screening laboratory services</b> Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.</li> <li>• <b>Bone mineral density (dexa scan) to screen for osteoporosis</b></li> <li>• <b>Chlamydia screening</b></li> <li>• <b>HPV Screening / counseling</b></li> <li>• <b>Ultrasound to screen for an abdominal aortic aneurysm</b></li> <li>• <b>Immunizations and vaccinations</b> (including those needed for travel)</li> <li>• <b>Flu vaccine</b> (including FluMist)</li> <li>• <b>Preventive dental care for children up to age 19</b> (Includes oral exam, prophylaxis, and fluoride treatment. Services limited to once every 180 days)</li> </ul>	<p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>1 per calendar year then subject to deductible and coinsurance</p> <p>Covered at 100%</p> <p>Covered at 100%</p> <p>Covered at 100%</p>	<p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p> <p>Subject to deductible and coinsurance</p>



<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Skilled nursing facility</b> (Limited to 100 days per disability)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Surgical services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Temporomandibular joint disorders or TMJ nonsurgical treatment</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Transplant services</b> <ul style="list-style-type: none"> <li>• <b>Organ Procurement and acquisition</b></li> <li>• <b>Transplant procedure</b></li> <li>• <b>Transportation and lodging</b></li> <li>• <b>Private duty nursing</b> (Limited to \$10,000 per transplant)</li> <li>• <b>Ambulance service</b> (Limited to \$2,000 per transplant)</li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<b>Vision examinations</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>All other covered</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance

**\*\* Case Management Requirement**

Participation in case management is mandatory. When a bill for hospitalization or ER occurs subsequent to a contact/offer from a SAS Case Manager that is declined, the first \$300 will not be considered for benefit payments. The balance would be considered subject to plan provisions.

**Note:**

Services received at VA facilities will be payable at the in-network level of benefits. UCR does not apply.



<b>Precertification Required</b>
<p>Contact Hines and Associates at 800.483.5984 or <a href="http://www.precertcare.com">www.precertcare.com</a></p>
<ul style="list-style-type: none"> <li>• All Inpatient hospitalizations</li> <li>• Skilled Nursing Facility and Residential Stays</li> <li>• Transplants</li> <li>• Physical, Occupational, and Speech therapy after 15 visits per calendar year</li> <li>• Second Surgical Opinions</li> <li>• Outpatient surgery including but not limited to:               <ul style="list-style-type: none"> <li>○ Abdominoplasty</li> <li>○ Carpel Tunnel Release</li> <li>○ Cosmetic/Reconstructive Surgery</li> <li>○ Hip Replacement</li> <li>○ Infuse Bone Graft</li> <li>○ Knee Replacement</li> <li>○ Panniculectomy</li> <li>○ Port Wine Stain – Abnormal Vascular Lesion Treatment</li> <li>○ Reduction Mammoplasty</li> <li>○ Rhinoplasty</li> <li>○ Septoplasty</li> <li>○ Spinal Cord Stimulator</li> </ul> </li> </ul>

<b>Pharmacy</b>	
<p>Preferred generic, preferred brand, non-preferred generic, non-preferred brand drugs, specialty drugs</p>	<p>Subject to deductible and coinsurance.</p> <p>Limited to a 100 day supply.</p> <p>100% coverage for Preventive Drugs (not subject to deductible). Please refer to the Preventive Medication List at <a href="http://www.sastpa.com">www.sastpa.com</a> for a list of covered products.</p> <p>If you use a non-participating pharmacy, you will need to pay for the prescription upfront and submit a claim reimbursement form with a receipt to Security Administrative Services for reimbursement. Reimbursement for covered prescription products will be based on the lowest contracted amount of a participating pharmacy minus any applicable deductible and/or copayment shown in this schedule.</p>