

HOLLYWOOD CHRYSLER PLYMOUTH, INC.
SUMMARY OF BENEFITS
RBP/PHCS WRAP BASE PLAN

EFFECTIVE: 02/01/2025

	NETWORK PROVIDERS/RBP FACILITY	OUT OF NETWORK PROVIDERS
MAXIMUM CALENDAR YEAR BENEFIT AMOUNT	None (unlimited)	
DEDUCTIBLE, PER CALENDAR YEAR		
Individual <i>(per covered person)</i>	\$3,500	
Family	\$7,000	
<p>The Plan has a non-embedded deductible. This means, for family coverage, the entire family Deductible must be satisfied (either by one individual or collectively by the family unit) before benefits subject to the deductible for a Covered Person in the family until will be considered for payment by the Plan.</p>		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Individual <i>(per covered person)</i>	\$9,000 <i>(includes copays, deductible and coinsurance)</i>	
Family	\$18,000 <i>(includes copays, deductible and coinsurance)</i>	
<p>For family coverage, the Plan has an embedded individual Maximum Out-of-Pocket Amount. This means Covered Services will be paid at 100% for a Covered Person in the family unit after the Covered Person meets a Maximum Out-of-Pocket Amount. The family unit must satisfy the family Maximum Out-of-Pocket Amount before the Plan will pay benefits at 100% for all Covered Persons in the family.</p> <p>The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.</p>		
<p>The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.</p> <ul style="list-style-type: none"> • Cost containment penalties • Non-Covered Expenses • Amounts that exceed an Allowable Charge • Amounts that exceed benefit maximums <p style="text-align: center;">NOTE: Prescription drug co-payments ARE included in the out-of-pocket maximum amount.</p>		

COVERED SERVICES

Percentages listed indicate the portion of the Allowable Charge that the Plan will pay in benefits subject to all exclusions and limitations described in this document. Copayments and deductibles are the Covered Person's responsibility to pay.

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
PREVENTIVE CARE		
The Plan will cover the following preventive services from a Network Provider with no charge for the Covered Person:		
<ul style="list-style-type: none"> ➤ Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force <i>except</i> for the recommendations issued in or around November of 2009 for breast cancer screening, mammography, and prevention are not considered to be current. ➤ Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. ➤ With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and ➤ With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. 		
<i>Benefits are subject to frequency guidelines set forth in the Affordable Care Act.</i>		
Routine Well Adult Care		
Office Visit including physical examination	100%, deductible waived	100%, deductible waived
Immunizations/flu shots	100%, deductible waived	100%, deductible waived
Lab tests and X-rays	100%, deductible waived	100%, deductible waived
Gynecological exam	100%, deductible waived	100%, deductible waived
Pap smear	100%, deductible waived	100%, deductible waived
Mammogram	100%, deductible waived	100%, deductible waived
Prostate exam/PSA	100%, deductible waived	100%, deductible waived
Bone Density	100%, deductible waived	100%, deductible waived
Endoscopic Tests (Sigmoidoscopy/Colonoscopy)	100%, deductible waived	100%, deductible waived
Routine Well Child Care (for individuals from age 0 up to age 18)		
Office Visit including physical exam	100%, deductible waived	100%, deductible waived
Lab tests and X-rays	100%, deductible waived	100%, deductible waived
Immunizations/Flu shots	100%, deductible waived	100%, deductible waived
Hearing Screenings	Not Covered except as required under the Affordable Care Act	Not Covered except as required under the Affordable Care Act
Vision Exam	Not Covered except as required under the Affordable Care Act	Not Covered except as required under the Affordable Care Act

INCENTIVIZED SERVICES	Incentive Based Providers	Non-Incentive Based Providers
Elective Surgery*/**	100% covered	70% after deductible
Major Diagnostic Imaging (MRI/MRA, CT & PET scans)*/**	100% covered	70% after deductible
Durable Medical Equipment*/**	100% covered	70% after deductible

*Requires Precertification

**To access the incentivized benefits, members must contact a WellNet Advocate and use a recommended provider. Deductible and coinsurance is waived if a member utilizes a WellNet recommended provider but only after the minimum IRS deductible has been satisfied.

PHCS – PRACTITIONER ONLY	IN-NETWORK PROVIDER (PHCS)	OUT-OF-NETWORK PROVIDERS (RBP)
PHYSICIAN SERVICES		
Office Visit – Primary Care Physician	70% after deductible	70% after deductible
Office Visit – Specialist Care Physician	70% after deductible	70% after deductible
Telephonic or Virtual Visits Primary Care Physician Specialist Care Physician	70% after deductible 70% after deductible	70% after deductible 70% after deductible
Inpatient Physician Visits (<i>Includes inpatient well newborn care</i>)	70% after deductible	70% after deductible
Spinal Manipulation/Chiropractic <i>Calendar Year maximum: 30 visits</i>	70% after deductible	70% after deductible
Applied Behavior Analysis <i>If medically necessary</i>	70% after deductible	70% after deductible
Physical Therapy <i>Calendar Year maximum: 30 visits</i>	70% after deductible	70% after deductible
Speech Therapy <i>Calendar Year maximum: 30 visits</i>	70% after deductible	70% after deductible
Occupational Therapy <i>Calendar Year maximum: 30 visits</i>	70% after deductible	70% after deductible
Maternity Services	70% after deductible <i>Deductible and coinsurance are waived for services included in the recommendations and guidelines listed above in this Schedule under preventive care (e.g., preventive prenatal and breastfeeding support services).</i>	70% after deductible <i>Deductible and coinsurance are waived for services included in the recommendations and guidelines listed above in this Schedule under preventive care (e.g., preventive prenatal and breastfeeding support services).</i>
MENTAL HEALTH DISORDERS		
Office Visit	70% after deductible	70% after deductible
SUBSTANCE USE DISORDERS		
Office Visit	70% after deductible	70% after deductible

PHCS – ANCILLARY	IN-NETWORK PROVIDER (PHCS)	OUT-OF-NETWORK PROVIDERS (RBP)
ANCILLARY SERVICES		
Ambulance Services	70% after deductible	
Labs <i>In an office setting, free standing facility, or independent lab</i>	70% after deductible	70% after deductible
X-Ray <i>In an office setting or free-standing facility</i>	70% after deductible	70% after deductible
Diagnostic Testing <i>In an office setting, free standing facility, or independent lab</i>	70% after deductible	70% after deductible
Maternity Services <i>Pregnancy expenses of Dependent Children are covered.</i>	70% after deductible <i>Deductible and coinsurance are waived for services included in the recommended guidelines listed above in this Schedule under preventive care (e.g., preventive prenatal and breastfeeding support services)</i>	70% after deductible <i>Deductible and coinsurance are waived for services included in the recommended guidelines listed above in this Schedule under preventive care (e.g., preventive prenatal and breastfeeding support services)</i>
Skilled Nursing Facility* <i>Calendar Year Maximum: 100 days</i>	70% after deductible	70% after deductible
Home Health Care* <i>Calendar Year maximum: 60 visits</i>	70% after deductible	70% after deductible
Infusion Therapy <i>Home or Office setting</i>	70% after deductible	70% after deductible
Hospice Care <i>Includes inpatient, outpatient, family bereavement, and counseling</i>	70% after deductible	70% after deductible
Urgent Care	70% after deductible	70% after deductible
Convenience Care Clinic	70% after deductible	70% after deductible
Chemotherapy*	70% after deductible	70% after deductible
Radiation Therapy*	70% after deductible	70% after deductible
Allergy Services <i>Includes serum, injections, and testing</i>	70% after deductible	70% after deductible
Prosthetics, Orthotics, Supplies, and Surgical Dressings	70% after deductible	70% after deductible

*Requires Precertification

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Telemedicine UCM	100%, deductible waived	Not Applicable

	REFERENCE BASED PRICING PROVIDERS
HOSPITAL SERVICES	
Room and Board* <i>Benefits payable at this facility's semi-private room rate</i>	70% after deductible
Intensive Care Unit* <i>Benefits payable at the facility's ICU rate</i>	70% after deductible
Outpatient Hospital Services (other than surgery)	70% after deductible
Emergency Room	70% after deductible
Anesthesia	70% after deductible
Labs, X-Rays and Diagnostic Testing <i>In a hospital setting</i>	70% after deductible

**Requires Precertification*

	REFERENCE BASED PRICING PROVIDERS
OTHER SERVICES	
Organ Transplants*	70% after deductible
Dialysis* <i>Limit: First 40 visits for outpatient renal dialysis</i>	70% after deductible
Wigs <i>Maximum: 1 per lifetime</i>	70% after deductible

**Requires Precertification*

	REFERENCE BASED PRICING PROVIDERS
MENTAL HEALTH DISORDERS	
Inpatient/Partial Hospitalization*	70% after deductible
Outpatient Facility	70% after deductible
SUBSTANCE USE DISORDER	
Inpatient/Partial Hospitalization*	70% after deductible
Outpatient Facility	70% after deductible

**Requires Precertification*

	REFERENCE BASED PRICING PROVIDERS
ALL OTHER COVERED SERVICES	70% after deductible

**PRESCRIPTION DRUG BENEFITS
RBP/PHCS WRAP BASE PLAN**

NOTE: If a Covered Person requests a Brand Name Drug instead of a Generic Drug recommended by the pharmacy, the Covered Person will pay the Brand Name Drug copayment as well as the prescription cost between the Brand Name and the Generic Drug. A Covered Person will not be required to pay the difference in price between a Brand Name and Generic Drug when the Physician writes “DAW,” or “Dispense as Written” on the prescription.

PRESCRIPTION DRUGS		
	RETAIL PHARMACY <i>30-day supply</i>	RETAIL/MAIL ORDER PHARMACY <i>90-day supply</i>
Generic (Tier 1)	\$10 copayment after deductible	\$20 copayment after deductible
Preferred Brand Name (Tier 2)	\$65 copayment after deductible	\$130 copayment after deductible
Non-Preferred Brand Name (Tier 3)	\$90 copayment after deductible	\$180 copayment after deductible
Preventive Drugs (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 copayment, deductible waived	\$0 copayment, deductible waived
SPECIALTY DRUGS		
	SPECIALTY PHARMACY <i>30- day supply</i>	
Specialty Generic	\$125 copayment after deductible	
Specialty Preferred Brand Name	\$125 copayment after deductible	
Specialty Non-Preferred Brand Name	\$125 copayment after deductible	

*** Please note, all Specialty medication must be obtained via the Specialty Pharmacy.**