

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

**EFFECTIVE: 02/01/2025**

	<b>NETWORK PROVIDERS/RBP FACILITY</b>	<b>OUT OF NETWORK PROVIDERS</b>
<b>MAXIMUM CALENDAR YEAR BENEFIT AMOUNT</b>	None (unlimited)	
<b>DEDUCTIBLE, PER CALENDAR YEAR</b>		
Individual <i>(per covered person)</i>	\$2,000	
Family	\$4,000	
<p>For family coverage, the Plan has an embedded individual Deductible Amount. This means the Deductible for a Covered Person in the family unit will be satisfied after the Covered Person meets the deductible. The family unit must satisfy the family Deductible before the Plan considers the Deductible met for all Covered Persons in the family.</p>		
<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</b>		
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"> <li>• Cost containment penalties</li> <li>• Non-Covered Expenses</li> <li>• Amounts that exceed an Allowable Charge</li> <li>• Amounts that exceed benefit maximums</li> </ul> <p style="text-align: center;"><b>NOTE: Prescription drug co-payments ARE included in the out-of-pocket maximum amount.</b></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.*

	NETWORK PROVIDERS/ RBP FACILITY	OUT OF NETWORK PROVIDERS
<b>PREVENTIVE CARE</b>		
The Plan will cover the following preventive services with no charge for the Covered Person:		
<ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ 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.</li> <li>➤ 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</li> <li>➤ With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>		
<i>Benefits are subject to frequency guidelines set forth in the Affordable Care Act.</i>		
<b>Routine Well Adult Care</b>		
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
<b>Routine Well Child Care (for individuals from age 0 up to age 18)</b>		
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
Vision Exam	Not Covered except as required under the Affordable Care Act	Not Covered

<b>INCENTIVIZED SERVICES</b>	<b>Incentive Based Providers</b>	<b>Non-Incentive Based Providers</b>
Elective Surgery*/** <i>Ambulatory Surgery Center</i>	100% covered	\$1750 copayment, deductible waived
Major Diagnostic Imaging (MRI/MRA, CT & PET scans)*/** <i>Freestanding Facility</i>	100% covered	\$250 copayment, deductible waived
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.

<b>PHCS – PRACTITIONER ONLY</b>	<b>IN-NETWORK PROVIDER (PHCS)</b>	<b>OUT-OF-NETWORK PROVIDERS (RBP)</b>
<b>PHYSICIAN SERVICES</b>		
Office Visit – Primary Care Physician <i>All services rendered in office visit</i>	\$25 copayment, deductible waived	\$25 copayment, deductible waived
Office Visit – Specialist Care Physician <i>All services rendered in office visit</i>	\$35 copayment, deductible waived	\$35 copayment, deductible waived
Telephonic or Virtual Visits Primary Care Physician Specialist Care Physician	\$25 copayment, deductible waived \$35 copayment, deductible waived	\$25 copayment, deductible waived \$35 copayment, deductible waived
Office Surgery – Dermatologist	\$100 copayment, deductible waived	\$100 copayment, deductible waived
Office Surgery – All Other Primary Care Physician Specialist Care Physician	\$25 copayment, deductible waived \$35 copayment, deductible waived	\$25 copayment, deductible waived \$35 copayment, deductible waived
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>	\$35 copayment, deductible waived	\$35 copayment, deductible waived
Applied Behavior Analysis <i>If medically necessary</i>	70% after deductible	70% after deductible
Physical Therapy <i>Calendar Year maximum: 30 visits</i>	\$35 copayment, deductible waived	\$35 copayment, deductible waived
Speech Therapy <i>Calendar Year maximum: 30 visits</i>	\$35 copayment, deductible waived	\$35 copayment, deductible waived
Occupational Therapy <i>Calendar Year maximum: 30 visits</i>	\$35 copayment, deductible waived	\$35 copayment, deductible waived
Maternity Services	100%, deductible waived <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>	100%, deductible waived <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>
<b>MENTAL HEALTH DISORDERS</b>		
Office Visit	\$25 copayment, deductible waived	\$25 copayment, deductible waived
<b>SUBSTANCE USE DISORDERS</b>		
Office Visit	\$25 copayment, deductible waived	\$25 copayment, deductible waived

<b>PHCS – ANCILLARY</b>	<b>IN-NETWORK PROVIDER (PHCS)</b>	<b>OUT-OF-NETWORK PROVIDERS (RBP)</b>
<b>ANCILLARY SERVICES</b>		
Ambulance Services	70% after deductible	
Labs <i>In an office setting, free standing facility, or independent lab</i>	100%, deductible waived	100%, deductible waived
X-Ray <i>In an office setting or free-standing facility</i>	100%, deductible waived	100%, deductible waived
Diagnostic Testing <i>In an office setting, free standing facility, or independent lab</i>	100%, deductible waived	100%, deductible waived
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>Plan 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 <i>All services rendered during visit</i>	\$150 copayment, deductible waived	\$150 copayment, deductible waived
Convenience Care Clinic	100%, deductible waived	100%, deductible waived
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

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

	<b>REFERENCE BASED PRICING PROVIDERS</b>
<b>HOSPITAL SERVICES</b>	
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
Elective Surgery*/** <i>Hospital Setting</i>	70% after deductible
Major Diagnostic Imaging (MRI/MRA, CT & PET scans)*/** <i>Hospital Setting</i>	70% after deductible
Outpatient Hospital Services (other than surgery)	70% after deductible
Emergency Room <i>All services rendered during visit</i>	\$500 copayment, deductible waived <i>(Copayment waived if admitted)</i>
Anesthesia	70% after deductible
Labs <i>In a hospital setting</i>	100%, deductible waived
X-Rays <i>In a hospital setting</i>	100%, deductible waived
Diagnostic Testing <i>In a hospital setting</i>	70% after deductible

*\*Requires Precertification*

	<b>REFERENCE BASED PRICING PROVIDERS</b>
<b>OTHER SERVICES</b>	
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*

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

*\*Requires Precertification*

	<b>REFERENCE BASED PRICING PROVIDERS</b>
<b>ALL OTHER COVERED SERVICES</b>	70% after deductible

**PRESCRIPTION DRUG BENEFITS  
RBP/PHCS WRAP ESSENTIAL 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.

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

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