Level Funded Employer High VEBA Plans

Synchrony Health Initiatives

Effective Date: 1/1/20

	Plan 3 Reference Based Reimbursement	Plan 4 Reference Based Reimbursement
Deductible & Maximums	**In-Network**	**In-Network**
Medical Deductible (Individual/Family)	$1,200/$2,400	$1,800/$3,600
Medical Out-of-Pocket Maximum - Individual/Family (includes deductible)	$3,000/$6,000	$3,600/$7,200
Prescription Deductible (Individual/Family)	$800/$1,600	$1,200/$2,400
Prescription Out-of-Pocket Maximum - Individual/Family (includes deductible)	$2,000/$4,000	$2,400/$4,800
Medical Coinsurance (Insurance/Patient)	80%/20%	80%/20%
Annual Maximum/Lifetime Maximum	Unlimited	Unlimited
Physician Services		
Preventative Care/Routine Exams	Covered at 100%	Covered at 100%
Primary Care - Office Visit	$40 Copay	$40 Copay
Specialist - Office Visit	$60 Copay	$60 Copay
Urgent Care Visit (designated Urgent Care clinic)	$60 Copay	$60 Copay
Diagnostic Services		
Routine Preventative Care - Exam/Screening	Covered at 100%	Covered at 100%
Diagnostic Laboratory	80% After Deductible	80% After Deductible
Diagnostic X-Ray	80% After Deductible	80% After Deductible
Diagnostic X-Ray for Complex Imaging Services	80% After Deductible	80% After Deductible
Emergency Medical Care		
Emergency Room Visit	$300 Copay	$300 Copay
Non-Emergency ER Visit	80% After Deductible	80% After Deductible
Ambulance	80% After Deductible	80% After Deductible
Hospital Care		
Inpatient Hospitalization	80% After Deductible	80% After Deductible
Outpatient Surgery	80% After Deductible	80% After Deductible
Mental Health and Substance Abuse Services		
Inpatient Detoxification	80% After Deductible	80% After Deductible
Inpatient Substance Abuse Rehab & Mental Health treatment	80% After Deductible	80% After Deductible
Outpatient Substance Abuse Rehab & Mental Health treatment	$60 Copay	$60 Copay
Prescription Benefits		
Generic (G)/Formulary Brand Name(FBN)/Non-Formulary Brand Name(NFBN)(1)(2)	20% (Min-Max): G $10-$20 / FBN $30-$50 / NFBN $50-$100	G 15% / FBN 30% / NFBN 50%
Specialty Drugs (limited to 30 day supplies) (1)(2)	20% (Max): G $50 / FBN $100 / NFBN $150	G 15%;$50 Max / FBN 30%; $100 Max / NFBN 50%;$150 Max
Retail/Mail Order (90-day Supply) (1)(2)	40% (Min-Max): G $20-$40 / FBN $60-$100 / NFBN $100-$200	N/A, 30 day supplies only except for HIV medications
Other Benefits		
Routine Eye Exam (Children)	Covered at 100%	Covered at 100%
Skilled Nursing Facility	80% After Deductible	80% After Deductible

1) All pharmacy is subject to annual prescription deductibles and out of pocket limits. Pharmacy copays will apply after prescription deductible is met and these copays will be applied to the out of pocket limits.

2) All pharmacy benefits, including all medications, are subject to formulary, clinical and administrative programs effective at the time of claim adjudication, prior to dispensing and are subject to change.

3) All Specialty pharmacy requires Clinical Pharmacy review and approval prior to dispensing.