HOLLYWOOD CHRYSLER PLYMOUTH, INC.
SUMMARY OF BENEFITS
ESSENTIAL EPO PLAN

Effective 02/01/2025

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT	None (unlimited)	
DEDUCTIBLE, PER CALENDAR YEAR		
Individual *(per covered person)*	$2,000	Not Applicable
Family	$4,000	Not Applicable

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.

MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Individual	$9,000 *(includes copays, deductible and coinsurance)*	Not Applicable
Family	$18,000 *(includes copays, deductible and coinsurance)*	Not Applicable

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.

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.

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.

- Cost containment penalties
- Non-Covered Expenses
- Amounts that exceed an Allowable Charge
- Amounts that exceed benefit maximums

NOTE: Prescription drug co-payments ARE included in the out-of-pocket maximum amount.

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: ➢ 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 *except* 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. *Benefits are subject to frequency guidelines set forth in the Affordable Care Act.*		
Routine Well Adult Care		
Office Visit including physical examination	100%, deductible waived	Not Covered
Immunizations/flu shots	100%, deductible waived	Not Covered
Lab tests and X-rays	100%, deductible waived	Not Covered
Gynecological exam	100%, deductible waived	Not Covered
Pap smear	100%, deductible waived	Not Covered
Mammogram	100%, deductible waived	Not Covered
Prostate exam/PSA	100%, deductible waived	Not Covered
Bone Density	100%, deductible waived	Not Covered
Endoscopic Tests (Sigmoidoscopy/Colonoscopy)	100%, deductible waived	Not Covered
Routine Well Child Care (for individuals from age 0 up to age 18)		
Office Visit including physical exam	100%, deductible waived	Not Covered
Lab tests and X-rays	100%, deductible waived	Not Covered
Immunizations/Flu shots	100%, deductible waived	Not Covered
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

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
HOSPITAL SERVICES		
Room and Board* *Benefits payable at the facility's semi-private room rate.*	70% after deductible	Not Covered
Inpatient Surgery*/** *In a hospital setting, including Surgeon Charges*	70% after deductible	Not Covered
Intensive Care Unit* *Benefits payable at facility's ICU rate.*	70% after deductible	Not Covered
Emergency Room *All services rendered during visit*	$500 copayment, deductible waived *Copayment waived if admitted*	
Lab *In a hospital setting*	100%, deductible waived	Not Covered
X-rays *In a hospital setting*	100%, deductible waived	Not Covered
Diagnostic Testing *In a hospital setting*	100%, deductible waived	Not Covered
Outpatient Surgery*/** *In a hospital setting, including Surgeon Charges*	70% after deductible	Not Covered
Major Diagnostic Imaging *(MRI/MRA, CT & PET scans)*/** *In a hospital setting*	70% after deductible	Not Covered
PHYSICIAN SERVICES		
Office Visit – Primary Care Physician *All services rendered in office visit*	$25 copayment, deductible waived	Not Covered
Office Visit – Specialist *All services rendered in office visit*	$35 copayment, deductible waived	Not Covered
Telephonic or Virtual Visits *Primary Care Physician* *Specialist Care Physician*	 $25 copayment, deductible waived $35 copayment, deductible waived	 Not Covered Not Covered
Office Surgery – Dermatologist	$100 copayment, deductible waived	Not Covered
Office Surgery – All other	100%, deductible waived	Not Covered
Convenience Care Clinic	100%, deductible waived	Not Covered
Telemedicine UCM	100%, deductible waived	Not Applicable

***Requires Precertification*

***Contact a WellNet Advocate for assistance locating 2-3 recommended High Quality Providers in your area. When utilizing a recommended provider your member cost share will be reimbursed via a HRA established by your Employer.*

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Ambulance Service	70% after in-network deductible	
Lab, X-rays and Diagnostic Testing *In an office setting or at a Freestanding Facility*	100%, deductible waived	Not Covered
Outpatient Surgery*/** *Ambulatory Surgical Center*	$1,750 copayment, deductible waived	Not Covered
Major Diagnostic Imaging *(MRI/MRA, CT & PET scans)**/** *Freestanding Facility*	$250 copayment, deductible waived	Not Covered
Skilled Nursing Facility* *Calendar Year Maximum: 100 days*	70% after deductible	Not Covered
Organ Transplants*	70% after deductible	Not Covered
Maternity Office Visits	100%, deductible waived	Not Covered
Maternity – Childbirth/Delivery Facility Services	70% after deductible	Not Covered
Maternity – Childbirth/Delivery Professional Services	70% after deductible	Not Covered
Home Health Care* *Calendar Year Maximum: 60 days*	70% after deductible	Not Covered
Outpatient Hospice Care	70% after deductible	Not Covered
Inpatient Hospice Care	70% after deductible	Not Covered
Applied Behavior Analysis *If medically necessary*	70% after deductible	Not Covered
Spinal Manipulation Chiropractic *Calendar Year Maximum: 30 visits*	$35 copayment, deductible waived	Not Covered
Occupational Therapy *Calendar Year Maximum: 30 visits*	$35 copayment, deductible waived	Not Covered
Physical Therapy *Calendar Year Maximum: 30 visits*	$35 copayment, deductible waived	Not Covered
Speech Therapy Benefit Year *Calendar Year Maximum: 30 visits*	$35 copayment, deductible waived	Not Covered
Urgent Care *All services rendered in office visit*	$150 copayment, deductible waived	Not Covered

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	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Allergy Services *Includes serum, injection, and testing*	70% after deductible	Not Covered
Chemotherapy*	70% after deductible	Not Covered
Radiation Therapy*	70% after deductible	Not Covered
Infusion Therapy*	70% after deductible	Not Covered
Dialysis *Limit: First 40 visits for outpatient renal dialysis*	70% after deductible	Not Covered
Durable Medical Equipment*/**	$250 copayment, deductible waived	Not Covered

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	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Mental Disorders		
Inpatient/Partial Hospitalization*	70% after deductible	Not Covered
Outpatient Facility	70% after deductible	Not Covered
Office Visit	$25 copayment, deductible waived	Not Covered
Substance Abuse		
Inpatient/Partial Hospitalization*	70% after deductible	Not Covered
Outpatient Facility	70% after deductible	Not Covered
Office Visit	$25 copayment, deductible waived	Not Covered

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	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
All Other Covered Services	70% after deductible	Not Covered

PRESCRIPTION DRUG BENEFIT
ESSENTIAL EPO 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 co-payment as well as the prescription costs between the Brand Name and Generic Drugs. A Covered Person will be required to pay the difference in price between a Brand Name and Generic Drug when a Physician writes "DAW," or "Dispense as Written" on the prescription.

PRESCRIPTION DRUGS		
	RETAIL PHARMACY *30-day supply*	**RETAIL/MAIL ORDER PHARMACY** *90-day supply*
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
SPECIALTY DRUGS		
	SPECIALTY PHARMACY *30- day supply*	
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.***