HealthPlans, Inc.

Summary of Benefits

Brattleboro Retreat — Silver Plan

*Medical Benefits for Group **B56** Effective 1/1/2020*

	Dartmouth Hitchcock Facility Services	HPHC & DH Non Facility In Network	Non-Network
Deductible & Out-of-Pocket			
Annual Calendar Year Deductible *Single* *Family*	 $2,500 $5,000	 $3,000 $6,000	 $6,000 $12,000
Annual Out-of-Pocket Maximum *(includes Deductible)* *Single* *Family*	 $4,500 $9,000	 $5,000 $10,000	 $10,000 $20,000
Preventive Care			
Routine Physicals & Gynecological Exams	Paid as Tier 2	100% deductible waived	70% allowed amount after deductible
Other Services			
Office Visit – Primary Care	Paid as Tier 2	$25 copay then 100%	70% allowed amount after deductible
Office Visit – Specialist Care	Paid as Tier 2	$50 copay then 100%	70% allowed amount after deductible
Chiropractic Visit *(12 visits per calendar year)*	Paid as Tier 2	$25 copay then 100%	Not Covered
Diagnostic Lab & X-Ray	Paid as Tier 2	80% after deductible	70% allowed amount after deductible
CT, MRI & PET Scan	Paid as Tier 2	80% after deductible	70% allowed amount after deductible
Outpatient Surgery	90% after deductible	80% after deductible	70% allowed amount after deductible
Inpatient Hospital	90% after deductible	80% after deductible	70% allowed amount after deductible
Behavioral Health Hospital Service	90% after deductible	80% after deductible	70% allowed amount after deductible
Behavioral Health Office Visit	Not Available	$25 copay then 100%	$25 copay then 100% allowed amount
Occupational and Physical Therapy (*30 visits per calendar year combined with Speech Therapy)*	Paid as Tier 2	$25 copay then 100%	70% allowed amount after deductible
Speech Therapy (*30 visits per calendar year combined with PT/OT)*	Paid as Tier 2	$25 copay then 100%	70% allowed amount after deductible
Ambulance	Not Available	80% after deductible	80% allowed amount after deductible
Emergency Room *(copay waived if admitted)*	Paid as Tier 2	$150 copay then 100%	$150 copay then 100%
Urgent Care	Paid as Tier 2	$100 copay then 100%	$100 copay then 100% allowed amount
Prescription Drug Benefits	**RxBeneftis**		
Retail Pharmacy (*up to a 30-day supply)*	$5 (Generic) / $30 (Preferred Brand) / $50 (Non-Preferred Brand)		
DH Mail Order *(up to a 90-day supply)*	$10 (Generic) / $60 (Preferred Brand) / $100 (Non-Preferred Brand)		

NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern. Please refer to your Plan Document and Amendments for complete details as well as the services that require prior authorization.