H&R Block

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	IN-NETWORK	
COST SHARING		
Annual Deductible	Individual	N / A
	Family	N / A
Plan Coinsurance (unless indicated otherwise)	20%	
Copayments	Primary	$15
	Specialist	$15
	Emergency Room	20%
Out-of-Pocket maximum (Includes Deductible)	Individual	$2,500
	Family	$7,500
Individual Out-of-Pocket maximum (Includes Deductible)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.	
Lifetime maximum	Unlimited	
Dependent Children	Eligible dependents are covered until the end of the month in which they turn 26.	
HOSPITAL BENEFITS	**You Pay**	
Inpatient	Covered At	20%
Precertification is required	Deductible	N / A
Inpatient Mental Health Benefits:	Covered At	20%
Precertification is required	Deductible	N / A
Inpatient Substance Abuse and Detox benefits:	Covered At	20%
	Deductible	N / A
Precertification is required		
Outpatient/Facility	Covered At	20%
Ambulatory surgery	Deductible	N/ A
Some services may require Pre-certification		
Emergency Room/Facility	Covered At	20%
Covered for Medical Emergency only	Deductible	N/ A
OTHER FACILITY BENEFITS		
Home Health Care:	Covered At	No Charge
	Deductible	N / A
Home IV Therapy visits are not counted toward the maximum.		
Precertification is required		
Hospice	Covered At	No Charge
Precertification is required	Deductible	N / A
Skilled Nursing Facility	Covered At	20%
Limited to 120 days per calendar year, combined In and Out of Network	Deductible	N /A
Precertification is required		
INSTITUTIONAL (outpatient) AND PROFESSIONAL (any setting) CARE		
Alcohol/Substance Abuse Treatment and Detox	Covered At	$15/visit
Intensive Outpatient services are covered	Deductible	N/A
Precertification is required		
Mental Health Outpatient (inst. & prof.)	Covered At	$15/visit
Intensive Outpatient services are covered	Deductible	N/A
Occupational Therapy:	Covered At	$15/visit
Limited to 60 visits per calendar year (combined Physical, Occupational and Speech Therapy). Precertification is required.	Deductible	N / A
Professional and institutional combined; combined In and Out of Network.		
Additional visits may be received and are subject to medical necessity guidelines. There must be signs of significant progress.		
Physical Therapy:	Covered At	$15/visit
Limited to 60 visits per calendar year (combined Physical, Occupational and Speech Therapy). Precertification is required.	Deductible	N / A
Professional and institutional combined; combined In and Out of Network.		
Additional visits may be received and are subject to medical necessity guidelines. There must be signs of significant progress.		
Speech Therapy	Covered At	$15/visit
Limited to 60 visits per calendar year (combined Physical, Occupational and Speech Therapy). Precertification is required.	Deductible	N / A
Professional and institutional combined; combined In and Out of Network.		
Additional visits may be received and are subject to medical necessity guidelines. There must be signs of significant progress.		
X-Rays and Lab Tests (Non-routine)	Covered At	$15/day
	Deductible	N / A

	IN-NETWORK	
MEDICAL BENEFITS	**You Pay**	
Air and Ground Ambulance Must be medically necessary to be covered	Covered At Deductible	20% N /A
Allergy Care	Covered At Deductible	$15/visit N / A
Chiropractic Care	Covered At Deductible	$20/visit N/A
Durable Medical Equipment Diabetic supplies are covered at 50% Precertification required	Covered At Deductible	20% N / A
Exams - Routine Adult Physical The following Women's Preventive Services are covered at 100%: Annual Gynecological Exam, Mammography (screening), and Pap Smears (cervical cancer screening)	Covered At Deductible	No Cost N/A
Exams - Routine Well Child Care	Covered At Deductible	No Cost N/A
Immunizations (routine)	Covered At Deductible	No Cost N/A
Mammography (routine) No limit per calendar year on routine mammogram	Covered At Deductible	No Cost N/A
Maternity Care (professional charge)	Covered At Deductible	No Cost N / A
Transplant Services Precertification is required	Covered At Deductible	$15/visit N / A
Surgery Cosmetic Reconstructive Surgery (subject to medical necessity) Sterilization (Reversal of Sterilization is not Covered) Precertification is required	Covered At Deductible	$15/visit N / A

PHARMACY BENEFITS - Retail and Mail Order	**You pay**
Preventive Maintenance drugs Mail order	$3 per 30 day supply $6 per 90 day supply
Other Generic retail Other Generic mail order Brand-name retail Brand-name mail order	$15 per 30 day supply $30 per 90 day supply $50 per 30 day supply $100 per 90 day supply
Specialty drugs Specialty drugs does not qualify for mail order due to the sensitivity of the medicine	$200 per supply

NOTE: This is a benefit summary only and is subject to the terms, conditions, limitations, and exclusions set forth in more detail in your group health plan documents. The benefit summary is not a contract or guarantee of coverage and in the event of any discrepancy between the benefit summary and your group health plan documents, your group health plan documents will control. Benefits are available for covered services that are medically necessary. To qualify for benefits, patients must be eligible at the time of service.