# **APPENDIX B**

# **MEDICAL SCHEDULES OF BENEFITS**

# **Building Administrators**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
	None, except as may be applicable to	
Individual Annual Maximum	services that are n	ot considered to be
	Essential He	alth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:	00.1	
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100% (Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100% (Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Chemotherapy (Applies To Calendar Year	10070	3070
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:		
Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved		
By The FDA (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible     Durable Medical Equipment (Applies To Calendar	100 /0	00 /0
Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible Extended Care Facility Benefits Such As Skilled	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	30	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100%
T ald by Flatt After Deductible	10070	(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year Maximums):	•	• • •
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100% (Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100% (Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible  Mental Health Benefits:	100%	80%
Wental Health Benefits:		
Inpatient Or Partial Hospitalization: Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120 Days	
Paid By Plan	100%	100% (Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar Year Maximums)  Maximum Days Per Calendar Year Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will	30 E 80%	Days 80%
Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit Per Visit      Della Republication	-	40
Paid By Plan After Deductible	100%	80%
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):  Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
<ul> <li>Maximum Exams Per Calendar Year</li> <li>Paid By Plan</li> </ul>	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:	4000/	000/
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
	·	<del></del>

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>4</b>	
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Evnences (Applies To Colondor		
All Other Billed Expenses (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year	10070	00 /0
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
,		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	•	/isits
Paid By Plan After Deductible	100%	80%
r and by r lattrition boddetable		
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Coounctional Outpotiont Hospital And Office		
Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Paid by Plan After Deductible	(Deductible Waived)	00 /0
	(Doddollolo vvalvod)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):	_	
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):	·	
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
<ul> <li>Stay (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer	10070	3070
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 V	Vig
Maximum Benefit Per Lifetime	\$2	50
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
Du Destinius din a Detail Dhearne		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products	\$5 \$17.50	
Non-Preferred Brand Products  Maintenance Products (initial fill only)	\$35 Same as above	
By Participating Mail Order Pharmacy     Covered Person's Co-pay Amount Per     Prescription Product	For Up To A 90-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$10 \$35 \$70	
By Specialty Pharmacy Vendor  Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$5 \$17.50 \$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

# **Building Heads**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		١ . ا
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Notes True David Of Bartial Hamitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

<ul><li>Outpatient Treatment:</li><li>Maximum Visits Per Calendar Year</li><li>Paid By Plan</li></ul>	60 \	
	60 \	
A Doid By Dlon	1000/	
Falu by Flati	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
7 miles in an operation		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	1000/	4000/
Paid By Plan	100%	100% (Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100 /6	00 /6
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:	•	
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:		
Paid By Plan After Deductible	100%	80%
By The FDA (Applies To Calendar Year Maximums):	1000/	909/
Paid By Plan After Deductible  Durable Medical Equipment (Applies To Colondor)	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible Extended Care Facility Benefits Such As Skilled	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Innationt Consises Charges Boom And Board		
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room		
Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not	30	65
Apply To Calendar Year Maximums)	40004	1 000/
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Paid By Plan After Deductible	80%	80%
Lange Cont Plantation Of some (A. II. 7. O.)		
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
r and by r tarry more boardenests	.0070	
Inpatient Specialist Consultation (Applies To		
Calendar Year Maximums):	A \ \ (! = !4	Niat Amaliandia
Maximum Visits Per Period Of Confinement     Paid By Plan After Pediustible	1 Visit 100%	Not Applicable 80%
Paid By Plan After Deductible	100 /6	00 /0
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)
Cutaction Bhariain Channes Cala (Applies To		
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
•		
Outpatient Specialist Consultation (Applies To		
Calendar Year Maximums):  Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100%
1 ald by I lan Alter Deddelible	10070	(Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply		
To Calendar Year Maximums):  Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100%
. sid by that the boundaries	. 00,0	(Deductible Waived)
Outpatient Surgery Only (Does Not Apply To		
Calendar Year Maximums):  Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
1 ald by Flam Arter beddefible	10070	(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		,,
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
		(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	1000/	900/
Paid By Plan After Deductible  Mental Health Benefits:	100%	80%
Mental Fleatiff Benefits.		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not	120	Days
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
·		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80%
Niveana And Navibara Furzaca (Dasa Nat Assats		
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
1 ald by I lall	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  > Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	

Private Duty Nursing (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Radiation Therapy:  Hospital Billed Expenses (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan  Rodiation Therapy:  Sta		IN-NETWORK	OUT-OF-NETWORK
Radiation Therapy:  Hospital Billed Expenses (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible • Co-pay Per Visit • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even if The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible	• • • • • • • • • • • • • • • • • • • •		
Radiation Therapy:  Hospital Billed Expenses (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan After Deductible • Maximum Benefit Per Calendar Year Maximums):  Inpatient Or Partial Hospitalization • Maximum By One Day.  Outpatient Treatment • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan After Deductible  Mote: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling, Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible  Paid By Plan After Deductible  S18  Not Applicable 80%  (Deductible Waived)  Not Applicable 80%  (Deductible Waived)	•		
Hospital Billed Expenses (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible • Row Maximum Wistis Per Calendar Year • Paid By Plan After Deductible • Maximum Visits Per Calendar Year • Paid By Plan After Deductible • Maximum Wistis Per Calendar Year • Paid By Plan After Deductible • More: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible		100%	80%
Calendar Year Maximums):  Co-pay Per Visit Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization: Paid By Plan After Deductible Movinum Benefit Per Calendar Year Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: Co-pay Per Visit Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care. Therapy Services: Cocupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Maximum Visits Per Calendar Year Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Maximums): Co-pay Per Visit Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Advance Abuse	Radiation Therapy:		
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Co-pay Per Visit     Paid By Plan After Deductible     Paid By Plan A			
• Paid By Plan After Deductible  Sterilizations (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  • Paid By Plan After Deductible  Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  • Maximum Benefit Per Calendar Year  • Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18	•	\$18	Not Applicable
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• Paid By Plan After Deductible  Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  • Maximum Benefit Per Calendar Year  • Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counselling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Sala  Not Applicable  100%  (Deductible Waived)  Not Applicable  100%  (Deductible Waived)  Not Applicable  100%  (Deductible Waived)			
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Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  • Maximum Benefit Per Calendar Year  • Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Ilness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Co-pay Per Visit  \$18  Not Applicable  100%  80%  (Deductible Waived)			
<ul> <li>Maximum Benefit Per Calendar Year</li> <li>Paid By Plan After Deductible</li> <li>Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.</li> <li>Outpatient Treatment:         <ul> <li>Co-pay Per Visit</li> <li>Maximum Visits Per Calendar Year</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> </ul> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li>			
<ul> <li>Maximum Benefit Per Calendar Year</li> <li>Paid By Plan After Deductible</li> <li>Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.</li> <li>Outpatient Treatment:         <ul> <li>Co-pay Per Visit</li> <li>Maximum Visits Per Calendar Year</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> </ul> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li>	,		
Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:      Co-pay Per Visit     Paid By Plan After Deductible  Not Applicable  Not Applicable  60 Visits  100%  80%  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):      Co-pay Per Visit     Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):      Co-pay Per Visit     S18     S18     S18     S18     Paid By Plan After Deductible  100% 100%	Inpatient Or Partial Hospitalization:		
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Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  Co-pay Per Visit  Maximum Visits Per Calendar Year Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18	<ul> <li>Paid By Plan After Deductible</li> </ul>	80%	80%
Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  Co-pay Per Visit  Maximum Visits Per Calendar Year Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18			
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<ul> <li>Co-pay Per Visit</li> <li>Maximum Visits Per Calendar Year</li> <li>Paid By Plan After Deductible</li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li></ul></li></ul>	Outpatient Treatment:		
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<ul> <li>Paid By Plan After Deductible</li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>100%</li> <li>100%</li></ul></li></ul>	• •	-	
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Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  S18  \$18  \$18  \$100%	Therapy Services:		
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<ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>			
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Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 100%		(Deductible Mained)	
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Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit \$18 \$18  • Paid By Plan After Deductible \$100%			
Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan After Deductible  \$18 100%			
After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 100%			
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Paid By Plan After Deductible     100%     100%	·	\$18	\$18
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(2 Gadelinio Walvea)	<u> </u>		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Nig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
De Destinius din a Detail Di anno		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$5 \$17.50 \$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy     Covered Person's Co-pay Amount Per Prescription Product	For Up To A 90-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$10 \$35 \$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$5 \$17.50 \$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

#### Cafeteria

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as m	ay be applicable to
	services that are n	ot considered to be
	Essential He	alth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: The Desir Of Boot's His and the Proof on Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

Outpatient Treatment:  • Maximum Visits Per Calendar Year  • Paid By Plan  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Ambulance Transportation:  Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  • Paid By Plan  100%  100%  (Deductible Waived)  100%  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  80%  80%  80%  Volunteer Ambulance (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  80%  80%  80%  80%  80%  80%  80%  80		IN-NETWORK	OUT-OF-NETWORK
Paid By Plan 100% (Deductible Waived)  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Ambulance Transportation:  Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan 100% (Deductible Waived)  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  Paid By Plan After Deductible 80% 80%  Volunteer Ambulance (Applies To Calendar Year Maximums):  Paid By Plan After Deductible 80% 80%  Breast Pumps (Applies To Calendar Year Maximums):  Paid By Plan After Deductible 100% 80%  Chemotherapy (Applies To Calendar Year Maximums):  Paid By Plan After Deductible 100% 80%  Chemotherapy (Applies To Calendar Year Maximums):  Co-pay Per Visit \$18 Not Applicable 80%  Paid By Plan After Deductible 100% 80%  Chiropractic Services (Applies To Calendar Year Maximums):  Office Visit:  Co-pay Per Visit \$18 Not Applicable 80%  Manipulations:  Co-pay Per Visit \$18 Not Applicable 80%  Manipulations:  Co-pay Per Visit \$18 Not Applicable 80%  Paid By Plan After Deductible 100% 80%  X-rays:  Paid By Plan After Deductible 100% 80%  Variays:  Paid By Plan After Deductible 100% 80%  Not Applicable 100% 80%  Paid By Plan After Deductible 100% 80%  Not Applicable 80%  Paid By Plan After Deductible 100% 80%	-		
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Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even It The Affected Family Member Is Not Receiving Care.  Ambulance Transportation:  Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan  100%  100% (Deductible Waived)  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  80%  80%  80%  Volunteer Ambulance (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  80%  80%  80%  80%  80%  80%  80%  80	Paid By Plan	100%	
Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.   Ambulance Transportation:   Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):   Paid By Plan			(Deductible waived)
Ambulance Transportation:  Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Not Applicable  80%  Paid By Plan After Deductible  Not Applicable  80%  Paid By Plan After Deductible  100%  80%  Manipulations:  Co-pay Per Visit  Paid By Plan After Deductible  100%  80%  X-rays:  Paid By Plan After Deductible  100%  80%  Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  100%  80%  Durable Medical Equipment (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The		
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Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Breast Pumps (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Paid By Plan After Deductible  Co-pay Per Visit Paid By Plan After Deductible  Chiropractic Services (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible  Paid By Plan After Deductible  100%  80%  X-rays: Paid By Plan After Deductible  100%  80%  Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums): Paid By Plan After Deductible  100%  80%  Durable Medical Equipment (Applies To Calendar Year Maximums): Paid By Plan After Deductible	Paid By Plan	100%	
<ul> <li>Paid By Plan After Deductible</li> <li>Volunteer Ambulance (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Co-pay Per Visit</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Co-pay Per Visit</li> <li>Co-pay Per Visit</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Co-pay Per Visit</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Not Applicable</li> <li>Paid By Plan After Deductible</li> <li>Paid B</li></ul>	Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year		
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<ul> <li>Paid By Plan After Deductible</li> <li>Manipulations:</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>X-rays:</li> <li>Paid By Plan After Deductible</li> <li>Paid By Plan After Deductible</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul>		<b>.</b>	
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<ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>X-rays:</li> <li>Paid By Plan After Deductible</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul>	Paid By Plan After Deductible	100%	80%
<ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>X-rays:</li> <li>Paid By Plan After Deductible</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul>	Manipulations:		
<ul> <li>Paid By Plan After Deductible</li> <li>X-rays:         <ul> <li>Paid By Plan After Deductible</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):         <ul> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul> </li> </ul>		\$18	Not Applicable
<ul> <li>Paid By Plan After Deductible</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul>			
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  100%  80%	X-rays:		
By The FDA (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  100%  80%		100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):	By The FDA (Applies To Calendar Year Maximums):	4000/	0007
Year Maximums):		100%	80%
	Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	30	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100%
T ald by Flatt After Deductible	10070	(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
1 ald by Flam Arter beddefible	10070	(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		,,
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
		(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	1000/	900/
Paid By Plan After Deductible  Mental Health Benefits:	100%	80%
Mental Fleatiff Benefits.		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not	120	Days
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
·		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80%
Niveana And Navibara Furzaca (Dasa Nat Assats		
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
<ul> <li>Maximum Exams Per Calendar Year</li> <li>Paid By Plan</li> </ul>	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:	4000/	000/
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
	·	<del></del>

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>4</b>	
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Evnences (Applies To Colondor		
All Other Billed Expenses (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year	10070	00 /0
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
,		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	•	/isits
Paid By Plan After Deductible	100%	80%
r and by r lattrition boddetable		
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Coounctional Outpotiont Hospital And Office		
Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Paid by Plan After Deductible	(Deductible Waived)	00 /0
	(Doddollolo vvalvod)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):	_	
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Vig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
<ul> <li>By Participating Mail Order Pharmacy</li> <li>Covered Person's Co-pay Amount Per Prescription Product</li> </ul>	For Up To A 90-Day Supply:	
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

#### **CSEA**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$2,540	\$400
Per Family	\$5,080	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		١ . ا
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Notes True David Of Bartial Hamitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Ambulance transportation.		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	100%	100%
Paid By Plan	100 /6	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	00%
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved		2370
By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	30	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit     Daid By Plan Affect Dedicatible	\$18 100%	\$18 100%
Paid By Plan After Deductible	100%	(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
1 ald by Flam Arter beddefible	10070	(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		,,
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
		(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	1000/	900/
Paid By Plan After Deductible  Mental Health Benefits:	100%	80%
Mental Fleatiff Benefits.		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not	120	Days
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
·		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80%
Niveana And Navibara Furzaca (Dasa Nat Assats		
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:	4000/	000/
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
	·	<del></del>

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year	10070	0070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:	714	
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
nouse inputions maximum by one buy?		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note 20 Of The Order Cont Transfer and Visite Man De		
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpetient Heavital Theorem Within C		
Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Nig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy     Covered Person's Co-pay Amount Per     Prescription Product	For Up To A 90-Day Supply:	
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

### **Active Teachers**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	alth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$750
Per Family	\$15,800	\$750
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Davis Of Bowlink Hamitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100% (Deductible Waived)
		(Deductible Walved)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	4000/	900/
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
·		
X-rays:		
Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar		
Year Maximums):  Paid By Plan After Deductible	100%	80%
T aid by Fian Aitor boudolible	10070	5576

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Innationt Consises Charges Boom And Board		
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room		
Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not	30	65
Apply To Calendar Year Maximums)	40004	1 000/
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Paid By Plan After Deductible	80%	80%
Lange Cont Plantation Of some (A. II. 7. O.)		
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
r and by r tarry mor boadons.	.0070	
Inpatient Specialist Consultation (Applies To		
Calendar Year Maximums):	A \ \ (! = !4	Niat Amaliandia
Maximum Visits Per Period Of Confinement     Paid By Plan After Pediustible	1 Visit 100%	Not Applicable 80%
Paid By Plan After Deductible	100 /6	00 /0
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)
Cutaction Bhariain Channes Cala (Applies To		
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
•		
Outpatient Specialist Consultation (Applies To		
Calendar Year Maximums):  Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100%
1 ald by I lan Alter Deddelible	10070	(Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply		
To Calendar Year Maximums):  Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100%
. sid by that the boundaries	. 00,0	(Deductible Waived)
Outpatient Surgery Only (Does Not Apply To		
Calendar Year Maximums):  Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):	<b>4.0</b>	<b>A</b> 40
Co-pay Per Visit	\$18 4000/	\$18
Paid By Plan After Deductible	100%	100%
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		(Deductible Waived)
Maximums).		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:	1000/	100%
Paid By Plan	100%	(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):		(Deductible Walved)
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not	120	Days
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
		(Deductible Waived)
Afficial Aff		
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Maximum Days Per Calendar Year	30	Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment - Psychiatrist (Applies To		
Calendar Year Maximums):		
Maximum Benefit Per Visit	\$	40
Paid By Plan After Deductible	100%	80%
Outpatient Treatment (Applies To LCSW, MSSW		No Benefit
and Psychologists) (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$27	
Paid By Plan After Deductible	100%	
Nursery And Newborn Expenses (Does Not Apply		
To Calendar Year Maximums):	A1 ( A	<b></b>
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):  • Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
<ul> <li>Maximum Exams Per Calendar Year</li> <li>Paid By Plan</li> </ul>	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
ald by Flair	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:		
<ul><li>Gestational Diabetes</li><li>Papillomavirus DNA Testing</li></ul>		
Counseling For Sexually Transmitted Infections (Provided Annually)*		
Counseling For Human Immune-deficiency Virus (Provided Annually)*		
<ul> <li>Breastfeeding Support, Supplies And Counseling</li> </ul>		
Counseling For Interpersonal And Domestic		
Violence For Women (Provided Annually)*  • Paid By Plan	100%	80%
·		(Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam:	4000/	
Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
All Other Billed Expenses (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year	10070	0070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Davis Of Bartial Heavitalization Will		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.		
Reduce inpatient maximum by One Day.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
r and by r rain, mor boddenbie	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):	<b>#</b> 40	0.40
Co-pay Per Visit      Co-pay Per Visit	\$18 400%	\$18
Paid By Plan After Deductible	100%	100%
		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Vig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy  Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:	
Covered Person's Co-pay Amount Per  Proposition Product		
Prescription Product		
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
Tron Floring Bland Florido	470	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires	
	Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

### **Central Office Administrators**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Davis Of David Heavitalization 1979		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
, and all and transportation		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	4000/	4000/
Paid By Plan	100%	100% (Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):  Paid By Plan After Deductible	100%	80%
Chemotherapy (Applies To Calendar Year	10070	0070
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved	10070	5570
By The FDA (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible     Durable Medical Equipment (Applies To Calendar	100/0	00 /0
Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	30	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100%
T ald by Flatt After Deductible	10070	(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	1000/	000/
Paid By Plan After Deductible     Infertility Treatment (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
		(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible  Mental Health Benefits:	100%	00%
Montal Floatin Bollonia.		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum	120	Dovo
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
,		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment - Psychiatrist (Applies To		
Calendar Year Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80% I
Outpatient Treatment (Applies To LCSW, MSSW and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
Co-pay Per Visit	\$27	
Paid By Plan After Deductible  Number Symposium (Dage Not Apply)	100%	
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
- Taid by Fidit / titol Doddottblo	10070	3370

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /6
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
ald by Flair	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:		
<ul><li>Gestational Diabetes</li><li>Papillomavirus DNA Testing</li></ul>		
Counseling For Sexually Transmitted Infections (Provided Annually)*		
Counseling For Human Immune-deficiency Virus (Provided Annually)*		
<ul> <li>Breastfeeding Support, Supplies And Counseling</li> </ul>		
Counseling For Interpersonal And Domestic		
Violence For Women (Provided Annually)*  • Paid By Plan	100%	80%
·		(Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam:	4000/	
Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>A</b> .0	0.0
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		3070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Reduce inpution maximum by one bay.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
inclupy ocivioca.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
District Outs of and its 171		
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
·		(Deductible Waived)
		,

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Vig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy  Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)  By Participating Mail Order Pharmacy  Covered Person's Co-pay Amount Per Prescription Product	\$6 \$18 \$45 Same as above For Up To A 90-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$9 \$27 \$67.50	
By Specialty Pharmacy Vendor  Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$6 \$18 \$45	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

# **Confidential Management**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Tive Days Of Bortiel Heavitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100%
		(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	4000/	900/
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
,		
X-rays:		
Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar		
Year Maximums):  Paid By Plan After Deductible	100%	80%
Faid by Flatt After Deductible	10070	0076

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	30	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100%
T ald by Flatt After Deductible	10070	(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	1000/	000/
Paid By Plan After Deductible     Infertility Treatment (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
		(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible  Mental Health Benefits:	100%	00%
Montal Floatin Bollonia.		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum	120	Dovo
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
,		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment - Psychiatrist (Applies To		
Calendar Year Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80% I
Outpatient Treatment (Applies To LCSW, MSSW and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
Co-pay Per Visit	\$27	
Paid By Plan After Deductible  Number Symposium (Dage Not Apply)	100%	
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
- Taid by Fidit / titol Doddottblo	10070	3370

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /6
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
ald by Flair	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:		
<ul><li>Gestational Diabetes</li><li>Papillomavirus DNA Testing</li></ul>		
Counseling For Sexually Transmitted Infections (Provided Annually)*		
Counseling For Human Immune-deficiency Virus (Provided Annually)*		
<ul> <li>Breastfeeding Support, Supplies And Counseling</li> </ul>		
Counseling For Interpersonal And Domestic		
Violence For Women (Provided Annually)*  • Paid By Plan	100%	80%
·		(Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam:	4000/	
Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>A</b> .0	0.0
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		3070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Reduce inpution maximum by one bay.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
inclupy ocivioca.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
District Outside the Market Control		
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
<u> </u>		(Deductible Waived)
		,

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):	41	
Maximum Benefit		Vig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products	\$6 \$18	
Non-Preferred Brand Products  Maintenance Products (initial fill only)	\$45 Same as above	
By Participating Mail Order Pharmacy     Covered Person's Co-pay Amount Per Prescription Product	For Up To A 90-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$9 \$27 \$67.50	
By Specialty Pharmacy Vendor  Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products  By Non-Participating Pharmacy	\$6 \$18 \$45  Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in Appendix D.	Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	

#### Nurses

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Ambulance transportation.		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	100%	100%
Paid By Plan	100%	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	00%
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved		2370
By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	30	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100%
T ald by Flatt After Deductible	10070	(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	1000/	000/
Paid By Plan After Deductible     Infertility Treatment (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
		(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible  Mental Health Benefits:	100%	00%
Montal Floatiff Bollotto.		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum	120	Dovo
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
,		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment - Psychiatrist (Applies To		
Calendar Year Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80% I
Outpatient Treatment (Applies To LCSW, MSSW and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
Co-pay Per Visit	\$27	
Paid By Plan After Deductible  Number Fundament (Dags Not Apply)	100%	
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
- Taid by Fidit / titol Doddottblo	10070	3370

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	Ф4 O	Not Applicable
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	Not Applicable 80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19	10070	3070
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
<ul> <li>Maximum Exams Per Calendar Year</li> <li>Paid By Plan</li> </ul>	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
ald by Flair	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:		
<ul><li>Gestational Diabetes</li><li>Papillomavirus DNA Testing</li></ul>		
Counseling For Sexually Transmitted Infections (Provided Annually)*		
Counseling For Human Immune-deficiency Virus (Provided Annually)*		
<ul> <li>Breastfeeding Support, Supplies And Counseling</li> </ul>		
Counseling For Interpersonal And Domestic		
Violence For Women (Provided Annually)*  • Paid By Plan	100%	80%
·		(Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam:	4000/	
Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>A</b> .0	0.0
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		3070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Reduce inpution maximum by one bay.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
inclupy ocivioca.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
District Outside the Market Control		
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
<u> </u>		(Deductible Waived)
		,

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Vig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$5 \$17.50 \$35	
Maintenance Products (initial fill only)  By Participating Mail Order Pharmacy	Same as above For Up To A 90-Day Supply:	
Covered Person's Co-pay Amount Per Prescription Product	Tor op to A 30-Day Suppry.	
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

### MEDICAL SCHEDULE OF BENEFITS

#### Office Staff

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Notes True David Of Bantial Hamitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100%
		(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	4000/	900/
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:		
Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar		
Year Maximums):  Paid By Plan After Deductible	100%	80%
Faid by Flatt After Deductible	10070	0076

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Innationt Consises Charges Boom And Board		
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room		
Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not	30	65
Apply To Calendar Year Maximums)	40004	1 000/
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Paid By Plan After Deductible	80%	80%
Lange Cont Plantation Of some (A. II. 7. O.)		
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
r and by r tarry more boardenests	.0070	
Inpatient Specialist Consultation (Applies To		
Calendar Year Maximums):	A \ \ (! = !4	Niat Amaliandia
Maximum Visits Per Period Of Confinement     Paid By Plan After Pediustible	1 Visit 100%	Not Applicable 80%
Paid By Plan After Deductible	100 /6	00 /0
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)
Cutaction Bhariain Channes Cala (Applies To		
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
•		
Outpatient Specialist Consultation (Applies To		
Calendar Year Maximums):  Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100%
1 ald by I lan Alter Deddelible	10070	(Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply		
To Calendar Year Maximums):  Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100%
. sid by that the boundaries	. 00,0	(Deductible Waived)
Outpatient Surgery Only (Does Not Apply To		
Calendar Year Maximums):  Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	4000/	2001
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):  Co-pay Per Visit	\$18	\$18
Co-pay Per Visit     Paid By Plan After Deductible	100%	100%
Faid by Flatt After Deductible	10070	(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		(Doddoniolo Walvod)
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
		(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible  Mental Health Benefits:	100%	80%
Inpatient Or Partial Hospitalization: Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)  Paid By Plan	120 100%	Days  100% (Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar Year Maximums)  Maximum Days Per Calendar Year  Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day	30 80%	Days 80%
Outpatient Treatment - Psychiatrist (Applies To Calendar Year Maximums):  • Maximum Benefit Per Visit  • Paid By Plan After Deductible	100%	80%
Outpatient Treatment (Applies To LCSW, MSSW and Psychologists) (Applies To Calendar Year Maximums):	\$27	No Benefit
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	φ2 <i>1</i> 100%	
Nursery And Newborn Expenses (Does Not Apply	100,0	
To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /6
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
ald by Flair	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:		
<ul><li>Gestational Diabetes</li><li>Papillomavirus DNA Testing</li></ul>		
Counseling For Sexually Transmitted Infections (Provided Annually)*		
Counseling For Human Immune-deficiency Virus (Provided Annually)*		
<ul> <li>Breastfeeding Support, Supplies And Counseling</li> </ul>		
Counseling For Interpersonal And Domestic		
Violence For Women (Provided Annually)*  • Paid By Plan	100%	80%
·		(Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam:	4000/	
Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>A</b> .0	0.0
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		3070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Reduce inpution maximum by one bay.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
inclupy ocivioca.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
District Outside the Market Control		
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
<u> </u>		(Deductible Waived)
		,

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Vig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:	
Covered Person's Co-pay Amount Per Prescription Product		
Frescription Froduct		
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

### MEDICAL SCHEDULE OF BENEFITS

## **Paraprofessionals**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Notes True David Of Bartial Hamitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100%
1 ald by I lain	10070	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
<ul><li>Maximums):</li><li>Paid By Plan After Deductible</li></ul>	100%	80%
Chemotherapy (Applies To Calendar Year	10070	0070
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:	• • •	
Co-pay Per Visit	\$18 4000/	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:	40007	000/
Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible     Durable Medical Equipment (Applies To Calendar	10070	00 /0
Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Innationt Consises Charges Boom And Board		
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room		
Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not	30	65
Apply To Calendar Year Maximums)	40004	1 000/
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Paid By Plan After Deductible	80%	80%
Lange Cont Plantation Of some (A. II. 7. O.)		
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
r and by r tarry mor boadons.	.0070	
Inpatient Specialist Consultation (Applies To		
Calendar Year Maximums):	A \ \ (! = !4	Niat Amaliandia
Maximum Visits Per Period Of Confinement     Paid By Plan After Pediustible	1 Visit 100%	Not Applicable 80%
Paid By Plan After Deductible	100 /6	00 /0
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)
Cutaction Bhariain Channes Cala (Applies To		
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
•		
Outpatient Specialist Consultation (Applies To		
Calendar Year Maximums):  Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100%
1 ald by I lan Alter Deddelible	10070	(Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply		
To Calendar Year Maximums):  Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100%
. sid by that the boundaries	. 00,0	(Deductible Waived)
Outpatient Surgery Only (Does Not Apply To		
Calendar Year Maximums):  Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	1000/	000/
Paid By Plan After Deductible     Infertility Treatment (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
,		(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
		(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible  Mental Health Benefits:	100%	00%
Montal Floatiff Bollotto.		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum	120	Dovo
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
,		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment - Psychiatrist (Applies To		
Calendar Year Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80% I
Outpatient Treatment (Applies To LCSW, MSSW and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
Co-pay Per Visit	\$27	
Paid By Plan After Deductible  Number Fundament (Dags Not Apply)	100%	
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
- Taid by Fidit / titol Doddottblo	10070	3370

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /6
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
ald by Flair	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:		
<ul><li>Gestational Diabetes</li><li>Papillomavirus DNA Testing</li></ul>		
Counseling For Sexually Transmitted Infections (Provided Annually)*		
Counseling For Human Immune-deficiency Virus (Provided Annually)*		
<ul> <li>Breastfeeding Support, Supplies And Counseling</li> </ul>		
Counseling For Interpersonal And Domestic		
Violence For Women (Provided Annually)*  • Paid By Plan	100%	80%
·		(Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam:	4000/	
Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
All Other Billed Expenses (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year	10070	0070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
Note: Two Davis Of Bartial Heavitalization Will		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.		
Reduce inpatient maximum by One Day.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
r and by r rain, into boundario	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):	<b>#</b> 40	0.40
Co-pay Per Visit      Co-pay Per Visit	\$18 400%	\$18
Paid By Plan After Deductible	100%	100%
		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
<ul> <li>Stay (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		3070
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 V	Vig
Maximum Benefit Per Lifetime	\$2	50
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar	4000/	
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:	
Covered Person's Co-pay Amount Per Prescription Product		
Frescription Froduct		
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

## MEDICAL SCHEDULE OF BENEFITS

# **Teaching Assistants**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	alth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$750
Per Family	\$15,800	\$750
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		l <u>.</u>
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: The Desir Of Boot's Life and the Proof on Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Ambulance transportation.		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	100%	100%
Paid By Plan	100 /6	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100 /0	00 /6
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved	10070	3370
By The FDA (Applies To Calendar Year Maximums):	10007	000/
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	30	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100%
T ald by Flatt After Deductible	10070	(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):	<b>4.0</b>	<b>A</b> 40
Co-pay Per Visit	\$18 4000/	\$18
Paid By Plan After Deductible	100%	100%
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		(Deductible Waived)
Maximums).		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:	1000/	100%
Paid By Plan	100%	(Deductible Waived)
Maternity (Applies To Calendar Year Maximums):		(Deductible Walved)
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not	120	Days
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120	Days
Paid By Plan	100%	100%
		(Deductible Waived)
Afficial Aff		
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Maximum Days Per Calendar Year	30	Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment - Psychiatrist (Applies To		
Calendar Year Maximums):		
Maximum Benefit Per Visit	\$	40
Paid By Plan After Deductible	100%	80%
Outpatient Treatment (Applies To LCSW, MSSW		No Benefit
and Psychologists) (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$27	
Paid By Plan After Deductible	100%	
Nursery And Newborn Expenses (Does Not Apply		
To Calendar Year Maximums):	A1 ( A	<b></b>
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /6
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
1 ald by I lall	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  > Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
. 314 5) 1 1411		

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
Year Maximums):	***	
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):	4000/	000/
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
<u> </u>	7 \\\	l eeks
Maximum Benefit Per Calendar Year  Paid By Plan After Deductible	80%	eeks 80%
Paid By Plan After Deductible	00%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Reduce inpatient maximum by one bay.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
7 4.4 2) 1.47		
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):	<b>#40</b>	Niet Ameliaakia
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
. ald by Figure 100 boddonolo	. 20,0	(Deductible Waived)
	I	(Doddollolo vvalvou)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
<ul> <li>Stay (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		3070
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 V	Vig
Maximum Benefit Per Lifetime	\$2	50
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar	4000/	
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:	
Covered Person's Co-pay Amount Per Prescription Product		
Frescription Froduct		
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

# **Retired Building Administrators**

Effective: 07-01-2013

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Reduce impatient maximum by One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100% (Deductible Waived)
Note: 20 Of The Outpotions Treatment Visite May De		
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	4009/	100%
Paid By Plan	100%	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	4000/	200/
Paid By Plan After Deductible     Character (Applies To Colon don Vege	100%	80%
Chemotherapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:	1000/	80%
Paid By Plan After Deductible     Contraceptive Methods And Counseling Approved	100%	OU 70
By The FDA (Applies To Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible  Purch la Madical Equipment (Applies To Colondor)	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day)  Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement  Paid Par Plan Affras Parkertikla	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	<b>0</b> 40	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	80%
·	10076	00 76
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
maximums).		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	80%
Maternity (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum		l
Maximum Days Per Calendar Year (Does Not	120	Days
Apply To Calendar Year Maximums)		,
Paid By Plan	100%	100%
		(Deductible Waived)
After Maximum In Catiatical (Applies To Calandar		
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Maximum Days Per Calendar Year	30 E	Days
Paid By Plan After Deductible	80%	80%
,		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80%
Nursery And Newborn Expenses (Does Not Apply		
To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
- I aid by I lait / liter beddetible		2070

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	Ф4 O	Not Applicable
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	Not Applicable 80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums):	10076	3070
From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
<ul> <li>Maximum Exams Per Calendar Year</li> <li>Paid By Plan</li> </ul>	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:	4000/	000/
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		(20000000000000000000000000000000000000
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>#40</b>	
Co-pay Per Visit     Daid But Place	\$18 1000/	200/
Paid By Plan	100%	80%
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Long than to On Bandal Harrist Harriston		
Inpatient Or Partial Hospitalization:	71/1	a alsa
Maximum Benefit Per Calendar Year  Paid By Plan After De dystikle	80%	eeks
Paid By Plan After Deductible	00%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Thouast inputions maximum by one buy?		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
Therapy Services.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
- I ald by I lall Alter Deductible	10070	5570

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 \	Vig
Maximum Benefit Per Lifetime	\$2	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SC	HEDULE OF BENEFITS
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:

Generic Products	\$5
Preferred Brand Products	\$17.50
Non-Preferred Brand Products	\$35
Maintenance Products (initial fill only)	Same as above
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:
Covered Person's Co-pay Amount Per	
Prescription Product	
Generic Products	\$10
Preferred Brand Products	\$35
Non-Preferred Brand Products	\$70
	·
By Specialty Pharmacy Vendor	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Occasio Bushada	05
Generic Products	\$5
Preferred Brand Products	\$17.50
Non-Preferred Brand Products	\$35
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires
	Payment For The Prescription Upfront. The
	Covered Person Can Then Submit A Claim
	Reimbursement Form With A Receipt To the
	Pharmacy Benefits Manager Identified In
	Appendix D For Reimbursement. Reimbursement For Covered Prescription
	Products Will Be Based On The Lowest
	Contracted Amount Of A Participating Pharmacy
	Minus Any Applicable Deductible And/Or Retail
	Co-pay Shown In This Schedule.
For any Prescription Drug questions, please contact	
the Pharmacy Benefits Manager identified in	
Appendix D.	

## **Retired Building Heads**

Effective: 07-01-2013

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Notes True David Of Bartial Hamitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100% (Deductible Waived)
		(= 000000000000000000000000000000000000
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):	2004	2004
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	10076	80 /6
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
<ul><li>X-rays:</li><li>Paid By Plan After Deductible</li></ul>	100%	80%
Contraceptive Methods And Counseling Approved	10070	0070
By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar		
Year Maximums):	4000/	0007
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
<ul> <li>Urgent Care (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$50 100%	Not Applicable 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  • Maximum Days Per Spell Of Illness  • Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not     Apply To Colon day Years Maximum a)	36	65
Apply To Calendar Year Maximums)  • Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)  Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
<ul><li>Maximum Visits Per Period Of Confinement</li><li>Paid By Plan After Deductible</li></ul>	1 Visit 100%	Not Applicable 80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit     Daid By Plan Affect Padvetible	\$18 100%	909/
Paid By Plan After Deductible	100%	80%
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18 1000/	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	<b>\$18</b>	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year		
Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:	1000/	900/
Paid By Plan     Maternity (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:	10076	0076
Inpatient Or Partial Hospitalization: Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)  Paid By Plan	120 100%	Days  100%  (Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar Year Maximums)  Maximum Days Per Calendar Year Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day	30 I 80%	Days   80%
Outpatient Treatment (Applies To Calendar Year Maximums):  • Maximum Benefit Per Visit  • Paid By Plan After Deductible	\$\ 100%	40   80%
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):  • Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
<ul><li>Preventive / Routine Hearing Exams:</li><li>Paid By Plan</li></ul>	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency Virus (Provided Annually)*</li> <li>Breastfeeding Support, Supplies And</li> </ul>		
Counseling  Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate		
Ages:  Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):	4000/	000/
Paid By Plan After Deductible  Padiation Thomasum	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
All Other Billed Evnences (Applies To Colondor		
All Other Billed Expenses (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year	10070	3070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year	7 W	eeks
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	·	isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):	<b>4</b>	
Co-pay Per Visit	\$18 4000/	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):	<b>#40</b>	
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Q00/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 V	Vig
Maximum Benefit Per Lifetime		250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$5 \$17.50 \$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy     Covered Person's Co-pay Amount Per     Prescription Product	For Up To A 90-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$10 \$35 \$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$5 \$17.50 \$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

#### **Retired Cafeteria**

Effective: 07-01-2013

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Notes True David Of Bantial Hamitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:	00.1	
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100% (Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Ambulance Transportation:		
Ambulance Transportation.		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100% (Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	4000/	000/
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:		
Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
		L

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
<ul> <li>Urgent Care (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$50 100%	Not Applicable 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  • Maximum Days Per Spell Of Illness  • Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement  Paid Par Plan Affras Parkertikla	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	<b>0</b> 40	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	80%
·	10076	00 76
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year		
Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:	1000/	900/
Paid By Plan     Maternity (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:	10076	0076
Inpatient Or Partial Hospitalization: Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)  Paid By Plan	120 100%	Days  100%  (Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar Year Maximums)  Maximum Days Per Calendar Year Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day	30 I 80%	Days   80%
Outpatient Treatment (Applies To Calendar Year Maximums):  • Maximum Benefit Per Visit  • Paid By Plan After Deductible	\$\ 100%	40   80%
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):  • Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
<ul><li>Preventive / Routine Hearing Exams:</li><li>Paid By Plan</li></ul>	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency Virus (Provided Annually)*</li> <li>Breastfeeding Support, Supplies And</li> </ul>		
Counseling  Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate		
Ages:  Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):	4000/	000/
Paid By Plan After Deductible  Padiation Thorony	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
All Other Billed Funences (Applies To Oclander		
All Other Billed Expenses (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year	10070	0070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year	7 W	l eeks
Paid By Plan After Deductible	80%	80%
r and by r lattrition boddetable		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpotiont Treatments		
Outpatient Treatment:  Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	·	/isits
Paid By Plan After Deductible	100%	80%
r and by r rain rinter boundaries		
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
Therapy Services.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):	<b>.</b>	
Co-pay Per Visit  Point B. Plan Affice B. Leville	\$18 400%	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 V	Vig
Maximum Benefit Per Lifetime		250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Brand Products	\$17.50	
Non-Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:	
Covered Person's Co-pay Amount Per	Tor op 10 A 30 Bay cuppry.	
Prescription Product		
1 rescription i roddot		
Generic Products	\$10	
Brand Products	\$35	
Non-Brand Products	\$70	
Non Brand Froducts	Ψ	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Brand Products	\$17.50	
Non-Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires	
	Payment For The Prescription Upfront. The	
	Covered Person Can Then Submit A Claim	
	Reimbursement Form With A Receipt To the	
	Pharmacy Benefits Manager Identified In	
	Appendix D For Reimbursement.	
	Reimbursement For Covered Prescription	
	Products Will Be Based On The Lowest	
	Contracted Amount Of A Participating Pharmacy	
	Minus Any Applicable Deductible And/Or Retail	
	Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact		
the Pharmacy Benefits Manager identified in		
Appendix D.		

### **Retired CSEA**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	alth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100% (Deductible Waived)
		(Deductible Walved)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	4000/	900/
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
·		
X-rays:	40007	000/
Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar		
Year Maximums):  Paid By Plan After Deductible	100%	80%
Faiu by Fian Aiter Deductible	10070	00 /6

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement  Paid Par Plan Affras Parkertikla	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	<b>0</b> 40	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	80%
·	10076	00 76
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):	<b>4</b>	
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year		
Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
· •··• = <b>,</b> · · •···		
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	80%
Maternity (Applies To Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum		I
Maximum Days Per Calendar Year (Does Not	120	Days
Apply To Calendar Year Maximums)		
Paid By Plan	100%	100%
		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year	30 [	Days
Paid By Plan After Deductible	80%	80%
Nata Tan David Of Bartlat Hannifell and Indian		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):	<b>c</b>	10
<ul><li>Maximum Benefit Per Visit</li><li>Paid By Plan After Deductible</li></ul>	۳ <sup>4</sup> 100%	40   80%
Faid by Flatt Attel Deductible	100 /0	00 /0
Name and American English (D. 1974)		
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
T AIU DY FIAIT AILEI DEUUCIDIE	10070	0070

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
1 ald by I lall	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
i ala by i lair		

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>#40</b>	
Co-pay Per Visit     Daid But Place	\$18 1000/	200/
Paid By Plan	100%	80%
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Long the st. On Bentled Heavy to Pentle s		
Inpatient Or Partial Hospitalization:	714	a alsa
Maximum Benefit Per Calendar Year  Paid By Plan After De dystikle	80%	eeks
Paid By Plan After Deductible	00%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Thouast inputions maximum by one buy?		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
Therapy Services.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
- I ald by I lall Alter Deductible	10070	5570

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 V	Vig
Maximum Benefit Per Lifetime		250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	
Covered reison's co-pay Amount	To op To A 30 Day Supply.	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:	
Covered Person's Co-pay Amount Per		
Prescription Product		
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
7.67.7.76.67.63 276.13 7.7633.66	<b>*</b>	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires	
	Payment For The Prescription Upfront. The	
	Covered Person Can Then Submit A Claim	
	Reimbursement Form With A Receipt To the	
	Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.	
	Reimbursement For Covered Prescription	
	Products Will Be Based On The Lowest	
	Contracted Amount Of A Participating Pharmacy	
	Minus Any Applicable Deductible And/Or Retail	
For any Drossintian Drug guestions, places, sentent	Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

## MEDICAL SCHEDULE OF BENEFITS

#### **Retired Central Office Administrators**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Davis Of David Heavitalization 1979		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.  Ambulance Transportation:		
Ambulance transportation.		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	100%	100%
Paid By Plan	100%	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100 /6	00 /6
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved		2370
By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
<ul> <li>Urgent Care (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$50 100%	Not Applicable 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  • Maximum Days Per Spell Of Illness  • Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement  Paid Par Plan Affras Parkertikla	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	<b>0</b> 40	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	80%
·	10076	00 76
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
maximums).		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	80%
Maternity (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum		l
Maximum Days Per Calendar Year (Does Not	120	Days
Apply To Calendar Year Maximums)		,
Paid By Plan	100%	100%
		(Deductible Waived)
After Maximum In Catisfied (Applies To Calander		
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Maximum Days Per Calendar Year	30 E	Days
Paid By Plan After Deductible	80%	80%
,		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80%
Nursery And Newborn Expenses (Does Not Apply		
To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
- I aid by I lait / liter beddetible		2070

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
1 ald by I lall	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
i ala by i lair		

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
	10070	0070
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):	4000/	2007
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year	7 W	eeks
Paid By Plan After Deductible	80%	80%
1 did by Fidit / titol boddottible	0070	3070
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpatient Treatment:	<b>.</b>	
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year		/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):	<b>A</b> 4 5	
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):	41)	AC.
Maximum Benefit     Maximum Benefit Benef		Nig
Maximum Benefit Per Lifetime  Reid Rus Plan After Reductible	•	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS	
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:

Generic Products	\$6
Preferred Brand Products	\$18
Non-Preferred Brand Products	\$45
Maintenance Products (initial fill only)	Same as above
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:
Covered Person's Co-pay Amount Per Prescription Product	
Generic Products	\$9
Preferred Brand Products	\$27
Non-Preferred Brand Products	\$67.50
By Specialty Pharmacy Vendor	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Generic Products	\$6
Preferred Brand Products	\$18
Non-Preferred Brand Products	\$45
For any Prescription Drug questions, please contact	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In <b>Appendix D</b> For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.
the Pharmacy Benefits Manager identified in <b>Appendix D</b> .	

# MEDICAL SCHEDULE OF BENEFITS

# **Retired Management/Confidential**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		<u> </u>
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100% (Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):		
Paid By Plan	100%	100% (Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	4000/	2004
Paid By Plan After Deductible  Character Analisa To Colon day Year	100%	80%
Chemotherapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:	100%	80%
Paid By Plan After Deductible     Contraceptive Methods And Counseling Approved	100 /0	OU /0
By The FDA (Applies To Calendar Year Maximums):	40007	000/
Paid By Plan After Deductible  Parallel Medical Facility and (Applies To Colondon)	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
<ul> <li>Urgent Care (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$50 100%	Not Applicable 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  • Maximum Days Per Spell Of Illness  • Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement  Paid Par Plan Affras Parkertikla	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	<b>0</b> 40	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	80%
·	10076	00 76
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):	<b>4</b>	
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year		
Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
· •··• = <b>,</b> · · •···		
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	80%
Maternity (Applies To Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum		I
Maximum Days Per Calendar Year (Does Not	120	Days
Apply To Calendar Year Maximums)		
Paid By Plan	100%	100%
		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year	30 [	Days
Paid By Plan After Deductible	80%	80%
Nata Tan David Of Bartlat Hannifell and Indian		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):	<b>c</b>	10
<ul><li>Maximum Benefit Per Visit</li><li>Paid By Plan After Deductible</li></ul>	۳ <sup>4</sup> 100%	40   80%
Faid by Flatt Attel Deductible	100 /0	00 /0
Name and American English (D. 1974)		
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
T AIU DY FIAIT AILEI DEUUCIDIE	10070	0070

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
1 ald by I lall	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
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	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
	10070	0070
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):	4000/	2007
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year	7 W	eeks
Paid By Plan After Deductible	80%	80%
1 did by Fidit / titol boddottible	0070	3070
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpatient Treatment:	<b>.</b>	
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year		/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):	<b>A</b> 4 5	
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Wig
Maximum Benefit Per Lifetime  Paid Par Plan After Perduetible	•	S250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

	PRESCRIPTION SCHEDULE OF BENEFITS
By Participating Retail	harmacy

Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Generic Products	\$6
Preferred Brand Products	\$18
Non-Preferred Brand Products	\$45
Maintenance Products (initial fill only)	Same as above
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:
Covered Person's Co-pay Amount Per	
Prescription Product	
Generic Products	\$9
Preferred Brand Products	\$27
Non-Preferred Brand Products	\$67.50
Non-Freieneu biand Froducts	\$67.50
By Specialty Pharmacy Vendor	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Generic Products	\$6
Preferred Brand Products	\$18
Non-Preferred Brand Products	\$45
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .	

## MEDICAL SCHEDULE OF BENEFITS

### **Retired Nurses**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Davis Of David Heavitalization 1979		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
7 mile and in an open anom		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	4000/	4000/
Paid By Plan	100%	100% (Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100 /6	00 /6
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:	<b>.</b>	
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:		
Paid By Plan After Deductible	100%	80%
By The FDA (Applies To Calendar Year Maximums):	1000/	909/
Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar)	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
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	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$18 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:     Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement  Paid Par Plan Affras Parkertikla	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	<b>0</b> 40	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	80%
·	10076	00 76
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
maximums).		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	80%
Maternity (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum		l
Maximum Days Per Calendar Year (Does Not	120	Days
Apply To Calendar Year Maximums)		,
Paid By Plan	100%	100%
		(Deductible Waived)
After Maximum In Catiatical (Applies To Calandar		
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Maximum Days Per Calendar Year	30 E	Days
Paid By Plan After Deductible	80%	80%
,		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80%
Nursery And Newborn Expenses (Does Not Apply		
To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
- I aid by I lait / liter beddetible		2070

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
1 ald by I lall	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
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	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>#40</b>	
Co-pay Per Visit     Daid By Plan	\$18 1000/	200/
Paid By Plan	100%	80%
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Long than to On Bandal Harrist Harriston		
Inpatient Or Partial Hospitalization:	71/1	a alsa
Maximum Benefit Per Calendar Year  Paid By Plan After De dystikle	80%	eeks
Paid By Plan After Deductible	00%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Thousand in aximum by one buy?		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
Therapy Services.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
- I ald by I lall Alter Deductible	10070	5570

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 \	Vig
Maximum Benefit Per Lifetime	\$250	
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS		
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:	

Generic Products	\$5
Preferred Brand Products	\$17.50
Non-Preferred Brand Products	\$35
Maintenance Products (initial fill only)	Same as above
By Participating Mail Order Pharmacy	For Up To A 90-Day Supply:
Covered Person's Co-pay Amount Per Prescription Product	
Generic Products	\$10
Preferred Brand Products	\$35
Non-Preferred Brand Products	\$70
By Specialty Pharmacy Vendor	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Generic Products	\$5
Preferred Brand Products	\$17.50
Non-Preferred Brand Products	\$35
By Non-Participating Pharmacy  For any Prescription Drug questions, please contact	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.
the Pharmacy Benefits Manager identified in Appendix D.	

#### **Retired Office Staff**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Notes True David Of Bantial Hamitalization Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Ambulance transportation.		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	100%	100%
Paid By Plan	100 /6	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	0070
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved		23,0
By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar		
Year Maximums):  Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
<ul> <li>Urgent Care (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$50 100%	Not Applicable 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  • Maximum Days Per Spell Of Illness  • Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement  Paid Par Plan Affras Parkertikla	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	<b>0</b> 40	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	80%
·	10076	00 76
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
maximums).		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	80%
Maternity (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum		l
Maximum Days Per Calendar Year (Does Not	120	Days
Apply To Calendar Year Maximums)		,
Paid By Plan	100%	100%
		(Deductible Waived)
After Maximum In Catiatical (Applies To Calandar		
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Maximum Days Per Calendar Year	30 E	Days
Paid By Plan After Deductible	80%	80%
,		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80%
Nursery And Newborn Expenses (Does Not Apply		
To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
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	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
,		
Preventive / Routine Hearing Exams:		
Paid By Plan	100%	80%
		(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80%
		(Deductible Waived)
In Addition, The Following Preventive / Routine		
Services Are Covered For Women:  > Gestational Diabetes		
Papillomavirus DNA Testing		
Counseling For Sexually Transmitted Infections (Provided Annually)*		
Counseling For Human Immune-deficiency		
Virus (Provided Annually)*  ➤ Breastfeeding Support, Supplies And		
Counseling		
Counseling For Interpersonal And Domestic		
Violence For Women (Provided Annually)*  • Paid By Plan	100%	80%
,		(Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children		No Benefit
Include (Does Not Apply To Calendar Year Maximums):		
Proventive / Douting Physical Evens		
Preventive / Routine Physical Exams:  Paid By Plan	100%	
·		
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And		
X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In		
Fluoride:  Paid By Plan	100%	
·		
Preventive / Routine Hearing Exam:  Paid By Plan	100%	
- raid Dy riuii	. 5576	I.

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>#40</b>	
Co-pay Per Visit     Daid But Place	\$18 1000/	200/
Paid By Plan	100%	80%
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Long than to On Bandal Harrist Harriston		
Inpatient Or Partial Hospitalization:	71/1	a alsa
Maximum Benefit Per Calendar Year  Paid By Plan After De dystikle	80%	eeks
Paid By Plan After Deductible	00%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Thouast inputions maximum by one buy?		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
Therapy Services.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
- I ald by I lall Alter Deductible	10070	5570

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):	4	Wig
Maximum Benefit     Maximum Benefit Ber Lifetime		Wig 3250
Maximum Benefit Per Lifetime     Daid By Plan After Deductible	100%	100%
Paid By Plan After Deductible	100%	(Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS	
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:

	<del>-</del>
Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)  By Participating Mail Order Pharmacy  Covered Person's Co-pay Amount Per Prescription Product	\$5 \$17.50 \$35 Same as above For Up To A 90-Day Supply:
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$10 \$35 \$70
By Specialty Pharmacy Vendor	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Generic Products Preferred Brand Products Non-Preferred Brand Products  By Non-Participating Pharmacy	\$5 \$17.50 \$35 Use Of A Non-Participating Pharmacy, Requires
	Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .	

### **Retired Paraprofessionals**

Effective: Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Davis Of David Hamitalization 1979		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100% (Deductible Waived)
		(Deductible Walved)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	4000/	900/
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100%	80%
Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
·		
X-rays:	40007	000/
Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar		
Year Maximums):  Paid By Plan After Deductible	100%	80%
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	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
<ul> <li>Urgent Care (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$50 100%	Not Applicable 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  • Maximum Days Per Spell Of Illness  • Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement  Paid Par Plan Affras Parkertikla	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	<b>0</b> 40	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	80%
·	10076	00 76
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	000/
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):	<b>4</b>	
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year		
Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	
Paid By Plan	100%	80%
· •··• = <b>,</b> · · •···		
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	80%
Maternity (Applies To Calendar Year Maximums):	4000/	000/
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum		I
Maximum Days Per Calendar Year (Does Not	120	Days
Apply To Calendar Year Maximums)		
Paid By Plan	100%	100%
		(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)		
Maximum Days Per Calendar Year	30 [	Days
Paid By Plan After Deductible	80%	80%
Nata Tan David Of Bartlat Hannifell and Indian		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year		
Maximums):	<b>c</b>	10
<ul><li>Maximum Benefit Per Visit</li><li>Paid By Plan After Deductible</li></ul>	۳ <sup>4</sup> 100%	40   80%
Faid by Flatt Attel Deductible	100 /0	00 /0
Name and American English (D. 1974)		
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
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	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$18 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:	4000/	000/
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		(20000000000000000000000000000000000000
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	<b>#40</b>	
Co-pay Per Visit     Daid But Place	\$18 1000/	200/
Paid By Plan	100%	80%
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Long than to On Bandal Harrist Harriston		
Inpatient Or Partial Hospitalization:	71/1	a alsa
Maximum Benefit Per Calendar Year  Paid By Plan After De dystikle	80%	eeks
Paid By Plan After Deductible	00%	80%
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Thouast inputions maximum by one buy?		
Outpatient Treatment:		
Co-pay Per Visit	\$18	Not Applicable
Maximum Visits Per Calendar Year	60 V	/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care. Therapy Services:		
Therapy Services.		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
	(Deductible Waived)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	
Paid By Plan After Deductible	100%	80%
- I ald by I lall Alter Deductible	10070	5570

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit	1 \	Vig
Maximum Benefit Per Lifetime	\$2	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS	
<ul><li>By Participating Retail Pharmacy</li><li>Covered Person's Co-pay Amount</li></ul>	For Up To A 30-Day Supply:

	•
Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)  By Participating Mail Order Pharmacy  Covered Person's Co-pay Amount Per Prescription Product	\$5 \$17.50 \$35 Same as above For Up To A 90-Day Supply:
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$10 \$35 \$70
By Specialty Pharmacy Vendor	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Generic Products Preferred Brand Products Non-Preferred Brand Products  By Non-Participating Pharmacy	\$5 \$17.50 \$35 Use Of A Non-Participating Pharmacy, Requires
	Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In <b>Appendix D</b> For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .	

# Teachers Retired Prior to September 1, 2011

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$750
Per Family	\$15,800	\$750
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Ambulance transportation.		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	100%	100%
Paid By Plan	100%	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100 /0	00 /6
Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved		2370
By The FDA (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
<ul> <li>Urgent Care (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$12 100%	Not Applicable 80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$50 100%	Not Applicable 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  • Maximum Days Per Spell Of Illness  • Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year		
Maximums):  Paid By Plan After Deductible	100%	80%
•		0070
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	36	55
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$12 100%	\$12 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$12	\$12
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$12	\$12
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit     Daid By Plan Affron Dadustikla	\$12 100%	\$12 100%
Paid By Plan After Deductible	100%	100% (Deductible Waived)
		(Doddotible vvalved)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	4000/	200/
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$12	\$12
Paid By Plan After Deductible	100%	100%
Faid by Flair Aiter Deductible	10070	(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		(Doddollale Walved)
Hospital Expense Benefits:		
Co-pay Per Visit	\$12	\$12
Paid By Plan	100%	100%
·		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
Maternity (Applies To Calendar Year Maximums):		(Deductible Waived)
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		3070
Inpatient Or Partial Hospitalization: Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)  Paid By Plan	120 Days	
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		(Deductible Waived)
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment - Psychiatrist and Psychologists only(Applies To Calendar Year Maximums):		
Maximum Benefit Per Visit	\$40	
Paid By Plan After Deductible	4004	1 222
	100%	80%
Nursery And Newborn Expenses (Does Not Apply		
To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>#40</b>	Not Applicable
Co-pay Per Visit     Doid By Plan After Deductible	\$12 100%	Not Applicable 80%
<ul> <li>Paid By Plan After Deductible</li> <li>Preventive / Routine Care Benefits. See Glossary</li> </ul>	100 /6	00 /0
Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
1 ald by I lall	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  > Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$12	\$12
Paid By Plan	100%	100%
		(Deductible Waived)
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year	10070	0070
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year		eeks
Paid By Plan After Deductible	80%	80%
N . T D 015 (111 11 11 11 11 11 11 11 11 11 11 11 1		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpatient Treatment:		
Co-pay Per Visit	\$12	Not Applicable
Maximum Visits Per Calendar Year	· · · · · · · · · · · · · · · · · · ·	/isits
Paid By Plan After Deductible	100%	80%
= 7		
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Paid by Plan Aiter Deductible	(Deductible Waived)	0070
	(Doddollalo vvalvou)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):		
Co-pay Per Visit	\$12	\$12
Paid By Plan After Deductible	100%	100%
		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$12 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer		
Treatment (Applies To Calendar Year Maximums):	4.1	) ()
Maximum Benefit     Maximum Benefit Benef		Vig
Maximum Benefit Per Lifetime  Belle After Benefit lettine	•	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar		,
Year Maximums):	100%	80%
Paid By Plan After Deductible		

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Brand Products Non-Brand Products Maintenance Products (initial fill only)  By Participating Mail Order Pharmacy  Covered Person's Co-pay Amount Per	\$0 \$10.00 \$20.00 Same as above For Up To A 90-Day Supply:	
Prescription Product  Generic Products	\$0	
Brand Products Non-Brand Products	\$20.00 \$40.00	
By Specialty Pharmacy Vendor	Faully Ta A 20 Day County	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Brand Products Non-Brand Products	\$0 \$10.00 \$20.00	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

## Teachers Retired on or after September 1, 2011

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	alth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$750
Per Family	\$15,800	\$750
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: The Desir Of Boot's His and the Proof on Will		
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

Outpatient Treatment:  • Maximum Visits Per Calendar Year  • Paid By Plan  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Ambulance Transportation:  Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  • Paid By Plan  100%  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  80%  80%  Volunteer Ambulance (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  80%  80%  80%  80%  80%  80%  80%  80		IN-NETWORK	OUT-OF-NETWORK
Paid By Plan 100% (Deductible Waived)  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Ambulance Transportation:  Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan 100% (Deductible Waived)  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  Paid By Plan After Deductible 80% 80%  Volunteer Ambulance (Applies To Calendar Year Maximums):  Paid By Plan After Deductible 80% 80%  Breast Pumps (Applies To Calendar Year Maximums):  Paid By Plan After Deductible 100% 80%  Chemotherapy (Applies To Calendar Year Maximums):  Paid By Plan After Deductible 100% 80%  Chemotherapy (Applies To Calendar Year Maximums):  Co-pay Per Visit \$18 Not Applicable 80%  Paid By Plan After Deductible 100% 80%  Chiropractic Services (Applies To Calendar Year Maximums):  Office Visit:  Paid By Plan After Deductible 100% 80%  Manipulations:  Co-pay Per Visit \$18 Not Applicable 80%  Manipulations:  Co-pay Per Visit \$18 Not Applicable 80%  Paid By Plan After Deductible 100% 80%  X-rays:  Paid By Plan After Deductible 100% 80%  Total By Plan After Deductible 100% 80%  Not Applicable 80%  Paid By Plan After Deductible 100% 80%  Not Applicable 80%  Paid By Plan After Deductible 100% 80%  Paid By Plan After Deductible 100% 80%  Paid By Plan After Deductible 100% 80%  Not Applicable 80%  Paid By Plan After Deductible 100% 80%  Paid By Plan After Deductible 100% 80%	· ·		
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling, Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.			
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Ambulance Transportation:  Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan  100%  100% (Deductible Waived)  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  80%  80%  80%  Volunteer Ambulance (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  80%  80%  80%  Breast Pumps (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  100%  80%  Chemotherapy (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  100%  80%  Chiropractic Services (Applies To Calendar Year Maximums):  Office Visit:  Co-pay Per Visit  100%  80%  Manipulations:  Co-pay Per Visit  Paid By Plan After Deductible  100%  80%  Manipulations:  Co-pay Per Visit  Paid By Plan After Deductible  100%  80%  X-rays:  Paid By Plan After Deductible  100%  80%  Not Applicable  80%  80%  Not Applicable  80%  80%  Manipulations:  Co-pay Per Visit  Paid By Plan After Deductible  100%  80%  Not Applicable  80%  80%  Manipulations:  Co-pay Per Visit  Paid By Plan After Deductible  100%  80%  Not Applicable  80%  80%  Manipulations:  Paid By Plan After Deductible  100%  80%  Not Applicable  80%  80%  Manipulations:  Paid By Plan After Deductible  100%  80%  Not Applicable  80%  80%  Not Applicable  80%  80%  80%	Paid By Plan	100%	
Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.   Ambulance Transportation:   Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):   Paid By Plan			(Deductible waived)
Ambulance Transportation:  Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Volunteer Ambulance (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Co-pay Per Visit  Paid By Plan After Deductible  Not Applicable  80%  Chiropractic Services (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Co-pay Per Visit  Paid By Plan After Deductible  100%  80%  Manipulations:  Co-pay Per Visit  Paid By Plan After Deductible  100%  80%  X-rays:  Paid By Plan After Deductible  100%  80%  Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  100%  80%  Durable Medical Equipment (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan  100%  Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non-Medical Emergency (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Paid By Plan After Deductible  80%  80%  80%  Volunteer Ambulance (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  80%  80%  80%  80%  80%  80%  80%  80			
Emergency (Does Not Apply To Calendar Year Maximums): Paid By Plan  100% Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums): Paid By Plan After Deductible Paid By Plan After Deductible  80% 80%  80%  80%  80%  80%  80%  80%	Ambulance Transportation.		
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<ul> <li>Paid By Plan After Deductible</li> <li>Volunteer Ambulance (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Breast Pumps (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Paid By Plan After Deductible</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Chiropractic Services (Applies To Calendar Year Maximums):</li> <li>Office Visit:</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Paid By Plan After Deductible</li> <li>Manipulations:</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Paid By Plan After Deductible</li> <li>Not Applicable</li> <li>80%</li> <li>Manipulations:</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>100%</li> <li>80%</li> <li>X-rays:</li> <li>Paid By Plan After Deductible</li> <li>100%</li> <li>80%</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>100%</li> <li>80%</li> </ul>	Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year		
Volunteer Ambulance (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Breast Pumps (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  100%  Chemotherapy (Applies To Calendar Year Maximums):  Co-pay Per Visit  Paid By Plan After Deductible  100%  Chiropractic Services (Applies To Calendar Year Maximums):  Office Visit:  Co-pay Per Visit  Paid By Plan After Deductible  100%  S0%  Chiropractic Services (Applies To Calendar Year Maximums):  Office Visit:  Co-pay Per Visit  Paid By Plan After Deductible  100%  Manipulations:  Co-pay Per Visit  Paid By Plan After Deductible  100%  Not Applicable  80%  X-rays:  Paid By Plan After Deductible  100%  80%  Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  100%  80%  Durable Medical Equipment (Applies To Calendar Year Maximums):		80%	80%
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<ul> <li>Paid By Plan After Deductible</li> <li>Chiropractic Services (Applies To Calendar Year Maximums):</li> <li>Office Visit:         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Manipulations:         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Manipulations:         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul>	· · · · · · · · · · · · · · · · · · ·	\$18	Not Applicable
Maximums):  Office Visit:  Co-pay Per Visit Paid By Plan After Deductible  Manipulations: Co-pay Per Visit Paid By Plan After Deductible  State of the paid By Plan After Deductible  X-rays: Paid By Plan After Deductible  Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums): Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar Year Maximums):  Office Visit State Sta	1 ' '	·	
<ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Manipulations:</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul>			
<ul> <li>Paid By Plan After Deductible</li> <li>Manipulations:</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>X-rays:</li> <li>Paid By Plan After Deductible</li> <li>Paid By Plan After Deductible</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul>	Office Visit:		
Manipulations:  Co-pay Per Visit Paid By Plan After Deductible  Y-rays: Paid By Plan After Deductible  100%  Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums): Paid By Plan After Deductible  100%  80%  100%  80%  100%  80%	· •	·	'''
<ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>X-rays:</li> <li>Paid By Plan After Deductible</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul>	Paid By Plan After Deductible	100%	80%
<ul> <li>Paid By Plan After Deductible</li> <li>X-rays:         <ul> <li>Paid By Plan After Deductible</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Contraceptive Methods And Counseling Approved         <ul> <li>By The FDA (Applies To Calendar Year Maximums):</li> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul> </li> </ul>	Manipulations:		
X-rays:  • Paid By Plan After Deductible  Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar Year Maximums):	Co-pay Per Visit		
<ul> <li>Paid By Plan After Deductible</li> <li>Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):         <ul> <li>Paid By Plan After Deductible</li> <li>Durable Medical Equipment (Applies To Calendar Year Maximums):</li> </ul> </li> </ul>	Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved By The FDA (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  100%  80%	· · · · · · · · · · · · · · · · · · ·	100%	80%
By The FDA (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  100%  80%		.0070	3370
Durable Medical Equipment (Applies To Calendar Year Maximums):	By The FDA (Applies To Calendar Year Maximums):	100%	800/
Year Maximums):		100%	00%
	Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
<ul> <li>Urgent Care (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>	\$18 100%	Not Applicable 80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$50 100%	Not Applicable 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  • Maximum Days Per Spell Of Illness  • Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)	365	
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	\$18 100% (Deductible Waived)
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$18	\$18
Paid By Plan After Deductible	100%	100% (Deductible Waived)
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit     Daid By Plan Affect Dedicatible	\$18 100%	\$18 100%
Paid By Plan After Deductible	100%	(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):	4000/	2007
Paid By Plan After Deductible     Infortility Treatment (Applies To Colon der Voor	100%	80%
Infertility Treatment (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	\$18
Paid By Plan After Deductible	100%	100%
, and by tham the boddening		(Deductible Waived)
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$18	\$18
Paid By Plan	100%	100%
		(Deductible Waived)
Office, Home (Medicare Certified), Or Free Standing Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	100%
Maternity (Applies To Calendar Year Maximums):		(Deductible Waived)
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization: Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	120 Days 100%   100%	
Paid By Plan	100 %	(Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		
Maximum Days Per Calendar Year		Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment - Psychiatrist and Psychologists only(Applies To Calendar Year Maximums):		
Maximum Benefit Per Visit		40
Paid By Plan After Deductible	100%	80%
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
•		

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>¢</b> 40	Not Applicable
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$18 100%	Not Applicable 80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include (Does	10076	3076
Not Apply To Calendar Year Maximums): From Age 19		
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams	1 Exam	
From Age 40  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:	4000/	000/
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
	·	<del></del>

Private Duty Nursing (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Radiation Therapy:  Hospital Billed Expenses (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan  Rodiation Therapy:  Sta		IN-NETWORK	OUT-OF-NETWORK
Radiation Therapy:  Hospital Billed Expenses (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible • Co-pay Per Visit • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even if The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible	• • • • • • • • • • • • • • • • • • • •		
Radiation Therapy:  Hospital Billed Expenses (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan After Deductible • Maximum Benefit Per Calendar Year Maximums):  Inpatient Or Partial Hospitalization • Maximum By One Day.  Outpatient Treatment • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan After Deductible  Mote: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling, Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible  Paid By Plan After Deductible  S18  Not Applicable 80%  (Deductible Waived)  Not Applicable 80%  (Deductible Waived)	•		
Hospital Billed Expenses (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible • Row Maximum Wistis Per Calendar Year • Paid By Plan After Deductible • Maximum Visits Per Calendar Year • Paid By Plan After Deductible • Maximum Wistis Per Calendar Year • Paid By Plan After Deductible • More: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible		100%	80%
Calendar Year Maximums):  Co-pay Per Visit Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization: Paid By Plan After Deductible Movinum Benefit Per Calendar Year Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: Co-pay Per Visit Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care. Therapy Services: Cocupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Maximum Visits Per Calendar Year Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Maximums): Co-pay Per Visit Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Advance Abuse	Radiation Therapy:		
Calendar Year Maximums):  Co-pay Per Visit Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization: Paid By Plan After Deductible Movinum Benefit Per Calendar Year Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: Co-pay Per Visit Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care. Therapy Services: Cocupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Maximum Visits Per Calendar Year Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Maximums): Co-pay Per Visit Paid By Plan After Deductible  Not Applicable Substance Abuse And Chemical Per Advance Abuse			
Co-pay Per Visit Paid By Plan Ster Deductible Paid By Plan After Deductible Physical Outpatient Treatment Visits May Be Used Even If The Affected Family Member Is Not Receiving Care. Paid By Plan After Deductible Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible			
Paid By Plan  All Other Billed Expenses (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Note: Paid By Plan After Deductible Paid By Plan After Deductible Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization: Maximum Benefit Per Calendar Year Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: Co-pay Per Visit Maximum Visits Per Calendar Year Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Co-pay Per Visit Sala Not Applicable Note: 20 Of The Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Co-pay Per Visit Sala Not Applicable Note Applicable Sala Not Applic	·	*	*
All Other Billed Expenses (Applies To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan After Deductible • Maximum Benefit Per Calendar Year Maximums):  Inpatient Or Partial Hospitalization: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible • Moving Per Visit • Co-pay Per Visit • Paid By Plan After Deductible • Maximum Visits Per Calendar Year • Paid By Plan After Deductible • Moving Visits • Paid By Plan After Deductible • Not Applicable • Not Applicable • Not Applicable • Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or in The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): • Capay Per Visit • Paid By Plan After Deductible  100%  100%	· ·	-	I -
All Other Billed Expenses (Applies To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan After Deductible • Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan After Deductible • Not Applicable • Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): • Co-pay Per Visit • Paid By Plan After Deductible  Physical Outpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): • Paid By Plan After Deductible	Paid By Plan	100%	
Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible 100% 80%  Sterilizations (Applies To Calendar Year Maximums): Paid By Plan After Deductible 100% 80%  Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization: Maximum Benefit Per Calendar Year Paid By Plan After Deductible 80%  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: Co-pay Per Visit Maximum Visits Per Calendar Year Paid By Plan After Deductible 100% 80%  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Capay Per Visit Paid By Plan After Deductible Stay Safter The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible Stay Safter The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible Stay Safter The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible Stay Safter The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible			(Deductible Walved)
Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible 100% 80%  Sterilizations (Applies To Calendar Year Maximums): Paid By Plan After Deductible 100% 80%  Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization: Maximum Benefit Per Calendar Year Paid By Plan After Deductible 80%  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment: Co-pay Per Visit Maximum Visits Per Calendar Year Paid By Plan After Deductible 100% 80%  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Capay Per Visit Paid By Plan After Deductible Stay Safter The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible Stay Safter The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible Stay Safter The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible Stay Safter The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Paid By Plan After Deductible	All Other Rilled Expenses (Applies To Calendar		
Co-pay Per Visit     Paid By Plan After Deductible     Paid By Plan A			
• Paid By Plan After Deductible  Sterilizations (Applies To Calendar Year Maximums):  • Paid By Plan After Deductible  • Paid By Plan After Deductible  Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  • Maximum Benefit Per Calendar Year  • Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18	•	\$18	Not Applicable
Sterilizations (Applies To Calendar Year Maximums):  Paid By Plan After Deductible  Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  Maximum Benefit Per Calendar Year  Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  Co-pay Per Visit  Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  Co-pay Per Visit  Paid By Plan After Deductible  Not Applicable  100%  \$18  Not Applicable  100%  (Deductible Waived)  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit  S18  Not Applicable  100%  (Deductible Waived)  S18  S18  S18  S18  Paid By Plan After Deductible  S0%	· ·	•	
Maximums):  Paid By Plan After Deductible Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  Maximum Benefit Per Calendar Year  Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  Co-pay Per Visit  Maximum Visits Per Calendar Year  Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Cocupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  Co-pay Per Visit  Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit  S18  Not Applicable  100%  (Deductible Waived)  Physical Outpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit  \$18  \$18  \$18  \$18  \$18  \$18  \$18  \$1		10070	0070
• Paid By Plan After Deductible  Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  • Maximum Benefit Per Calendar Year  • Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counselling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Sala  Not Applicable  100%  (Deductible Waived)  Not Applicable  100%  (Deductible Waived)  Physical Outpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Co-pay Per Visit  • Co-pay Per Visit  • Paid By Plan After Deductible  100%  Sala  100%			
Substance Abuse And Chemical Dependency Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  • Maximum Benefit Per Calendar Year  • Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  \$18  \$18  \$18  \$18  \$18  \$18  Paid By Plan After Deductible	•	100%	80%
Benefits (Applies To Calendar Year Maximums):  Inpatient Or Partial Hospitalization:  • Maximum Benefit Per Calendar Year  • Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Ilness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Co-pay Per Visit  \$18  Not Applicable  100%  80%  (Deductible Waived)			
<ul> <li>Maximum Benefit Per Calendar Year</li> <li>Paid By Plan After Deductible</li> <li>Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.</li> <li>Outpatient Treatment:         <ul> <li>Co-pay Per Visit</li> <li>Maximum Visits Per Calendar Year</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> </ul> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li>			
<ul> <li>Maximum Benefit Per Calendar Year</li> <li>Paid By Plan After Deductible</li> <li>Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.</li> <li>Outpatient Treatment:         <ul> <li>Co-pay Per Visit</li> <li>Maximum Visits Per Calendar Year</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> </ul> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li>	,		
Paid By Plan After Deductible  Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:      Co-pay Per Visit     Paid By Plan After Deductible  Not Applicable  Not Applicable  60 Visits  100%  80%  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):      Co-pay Per Visit     Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):      Co-pay Per Visit     S18     S18     S18     S18     Paid By Plan After Deductible  100% 100%	Inpatient Or Partial Hospitalization:		
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 \$18 \$18 \$18 \$18 \$18 \$100%	<ul> <li>Maximum Benefit Per Calendar Year</li> </ul>		1
Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  Co-pay Per Visit  Maximum Visits Per Calendar Year Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18	<ul> <li>Paid By Plan After Deductible</li> </ul>	80%	80%
Reduce Inpatient Maximum By One Day.  Outpatient Treatment:  Co-pay Per Visit  Maximum Visits Per Calendar Year Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums): Co-pay Per Visit Paid By Plan After Deductible  \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18 \$18			
Outpatient Treatment:  • Co-pay Per Visit  • Maximum Visits Per Calendar Year  • Paid By Plan After Deductible  Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18  \$18  \$18  \$18  \$18  \$18  \$19  \$100%			
<ul> <li>Co-pay Per Visit</li> <li>Maximum Visits Per Calendar Year</li> <li>Paid By Plan After Deductible</li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li></ul></li></ul>	Reduce Inpatient Maximum By One Day.		
<ul> <li>Co-pay Per Visit</li> <li>Maximum Visits Per Calendar Year</li> <li>Paid By Plan After Deductible</li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li></ul></li></ul>	Outpatient Treatment:		
<ul> <li>Maximum Visits Per Calendar Year</li> <li>Paid By Plan After Deductible</li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>S18 Not Applicable</li> <li>100% (Deductible Waived)</li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>\$18 \$18</li> <li>Paid By Plan After Deductible</li> </ul>	-	\$18	Not Applicable
<ul> <li>Paid By Plan After Deductible</li> <li>Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.</li> <li>Therapy Services:</li> <li>Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>100%</li> <li>100%</li></ul></li></ul>	• •	-	
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Stay Stay  \$18 \$18 \$18 \$18 \$100%			i
Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Stay  \$18 \$18 \$18 \$100%	. and by . iam , inter beddening		
Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Stay  \$18 \$18 \$18 \$18 \$100%	Note: 20 Of The Outpatient Treatment Visits May Be		
Affected Family Member Is Not Receiving Care.  Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Stay  \$18  \$18  \$18  \$18  \$100%			
Therapy Services:  Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Not Applicable 100%  Not Applicable 100%  80%  Not Applicable 100%  818  \$18  \$18  \$100%			
Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Not Applicable 100%  Not Applicable 100%  80%  Sample 100%  Not Applicable 100%  818 100%			
Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  S18  \$18  \$18  \$100%	Therapy Services:		
Therapy (Applies To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  S18  \$18  \$18  \$100%	Occupational Outpations Hagnital And Office		
<ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):</li> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul>			
<ul> <li>Paid By Plan After Deductible</li> <li>Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):         <ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> </ul> </li> <li>100%</li> <li>80%</li> <li>(Deductible Waived)</li> <li>80%</li> <li>(Deductible Waived)</li> <li>80%</li> <li>(Deductible Waived)</li> </ul> <li>80%</li> <li>(Deductible Waived)</li> <li>80%</li> <li>818</li> <ul> <li>\$18</li> <li>\$100%</li> <li>100%</li> </ul>		¢10	Not Applicable
Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  (Deductible Waived)   \$18 \$18 \$100%		•	
Physical Outpatient Hospital Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 \$100%	Paid by Plan After Deductible		0070
Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 100%		(Deductible Mained)	
Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 100%	Physical Outpatient Hospital Therapy Within 6		
Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit \$18 \$18  • Paid By Plan After Deductible \$100%			
Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit • Paid By Plan After Deductible  \$18 100%			
After Hospital Discharge (Does Not Apply To Calendar Year Maximums):  • Co-pay Per Visit  • Paid By Plan After Deductible  \$18 100%			
Calendar Year Maximums):  • Co-pay Per Visit \$18 \$18  • Paid By Plan After Deductible 100% 100%			
<ul> <li>Co-pay Per Visit</li> <li>Paid By Plan After Deductible</li> <li>\$18</li> <li>\$18</li> <li>\$100%</li> </ul>			
Paid By Plan After Deductible     100%     100%	·	\$18	\$18
	• •	100%	100%
(2 daddiblo Walvoa)	<u> </u>		(Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$18 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$18	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Vig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
Maintenance Products (initial fill only)	Same as above	
<ul> <li>By Participating Mail Order Pharmacy</li> <li>Covered Person's Co-pay Amount Per Prescription Product</li> </ul>	For Up To A 90-Day Supply:	
Generic Products	\$10	
Preferred Brand Products	\$35	
Non-Preferred Brand Products	\$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products	\$5	
Preferred Brand Products	\$17.50	
Non-Preferred Brand Products	\$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

## MEDICAL SCHEDULE OF BENEFITS

## **Retired Teaching Assistants**

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are not considered to be	
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$200
Per Family	\$0	\$500
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$500
Per Family	\$15,800	\$500
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		l .
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.  Ambulance Transportation:		
Ambulance Transportation:		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):  Paid By Plan	100%	100%
• Faid by Flair	100 /6	(Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
Maximums):	100%	80%
Paid By Plan After Deductible     Chemotherapy (Applies To Calendar Year	100 /0	00 /6
Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved	10070	5575
By The FDA (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar)	100%	OU%
Durable Medical Equipment (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$12 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
After Maximum Is Satisfied (Applies To Calendar Year Maximums)		'
Paid By Plan After Deductible	80%	80%
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement     Dai 18. Plant Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):	040	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$12 100%	80%
Outpatient Physician Charges Only (Applies To	10070	0070
Calendar Year Maximums)):  Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$12	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$12	
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$12	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):		
Co-pay Per Visit	\$12	
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
waxiiiuiiis).		
Hospital Expense Benefits:		
Co-pay Per Visit	\$12	
Paid By Plan	100%	80%
Office, Home (Medicare Certified), Or Free Standing		
Kidney Dialysis Facility Expense Benefits:		
Paid By Plan	100%	80%
Maternity (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
Included In Hospital Spell Of Illness Maximum	120.1	Dovo
Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)	1201	Days
Paid By Plan	100%	100%
- I did by I lali	10070	(Deductible Waived)
		,
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)	20.5	<b>N</b> aa
Maximum Days Per Calendar Year  Paid By Plan Affer Pedintible	80%	Days   80%
Paid By Plan After Deductible	0070	0076
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year Maximums):		
Maximum Sp.     Maximum Benefit Per Visit	.\$ <sub>2</sub>	1 40
Paid By Plan After Deductible	100%	80%
r did by r idir/ ittel beddetible	.00,0	3373
Nives and Annal March and Francisco (David March		
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):		
Maximum Benefit Per Admission	Not Applicable	\$75
Paid By Plan After Deductible	100%	80%
- I aid by I lait / liter beddetible		3373

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	<b>640</b>	Not Applicable
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	\$12 100%	Not Applicable 80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19	10070	3070
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
<ul> <li>Maximum Exams Per Calendar Year</li> <li>Paid By Plan</li> </ul>	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:  Paid By Plan	100%	80%
1 ald by I lall	10070	(Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)*  > Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
. 314 5, 1 1411		1

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hamital Billad Funances (Dass Not Apply To		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	\$12	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan</li></ul>	100%	80%
Paid By Plan	100 /6	00 /6
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year	7 W	l eeks
Paid By Plan After Deductible	80%	80%
1 ald by Flam Arter Deddelible	0070	0070
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpatient Treatment:		
Co-pay Per Visit	\$12	Not Applicable
Maximum Visits Per Calendar Year		/isits
Paid By Plan After Deductible	100%	80%
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occupational Outpatient Hospital And Office		
Therapy (Applies To Calendar Year Maximums):	<b>M40</b>	Niet Ameliechie
Co-pay Per Visit     Poid By Plan After Deductible	\$12 100%	Not Applicable
Paid By Plan After Deductible	100% (Deductible Waived)	80%
	(Deductible Walved)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):	<b>A</b>	
Co-pay Per Visit	\$12 4000/	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$12 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$12	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):		
Maximum Benefit		Vig
Maximum Benefit Per Lifetime	·	250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS		
By Participating Retail Pharmacy		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	\$5 \$17.50 \$35 Same as above	
<ul> <li>By Participating Mail Order Pharmacy</li> <li>Covered Person's Co-pay Amount Per Prescription Product</li> </ul>	For Up To A 90-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$10 \$35 \$70	
By Specialty Pharmacy Vendor		
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:	
Generic Products Preferred Brand Products Non-Preferred Brand Products	\$5 \$17.50 \$35	
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement.  Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.	
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .		

## **MEDICAL SCHEDULE OF BENEFITS**

## Retirees Contributing 20% to Premium Equivalents

Effective: 01-01-2019

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum	None, except as may be applicable to	
	services that are n	ot considered to be
	Essential He	ealth Benefits
Annual Deductible Per Calendar Year		
Per Person	\$0	\$400
Per Family	\$0	\$1,000
Plan Participation Rate, Unless Otherwise Stated		
Below:		
Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum		
Per Person	\$7,900	\$400
Per Family	\$15,800	\$400
Alcohol Rehabilitation (Does Not Apply To		
Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		<sub>.</sub>
Maximum Weeks Per Calendar Year	7 Weeks	
Paid By Plan	100%	100%
		(Deductible Waived)
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
Maximum Visits Per Calendar Year		/isits
Paid By Plan	100%	100%
		(Deductible Waived)
Note: 20 Of The Outpatient Treatment Visits May Be Used For Enrolled Family Member Counseling. Five Of The Twenty May Be Used Even If The Affected Family Member Is Not Receiving Care.		
Ambulance Transportation:		
Ambulance Transportation.		
Hospital Owned Billed By Hospital For Medical Emergency (Does Not Apply To Calendar Year Maximums):	1000/	1009/
Paid By Plan	100%	100% (Deductible Waived)
Professional Ambulance Billed For Emergency Or Non-Emergency Or Hospital Owned For Non- Medical Emergency (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Volunteer Ambulance (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	80%	80%
Breast Pumps (Applies To Calendar Year		
<ul><li>Maximums):</li><li>Paid By Plan After Deductible</li></ul>	100%	80%
Chemotherapy (Applies To Calendar Year	10070	0070
Maximums):		
Co-pay Per Visit	\$5	Not Applicable
Paid By Plan After Deductible	100%	80%
Chiropractic Services (Applies To Calendar Year Maximums):		
Office Visit:		
Co-pay Per Visit	<b>\$</b> 5	Not Applicable
Paid By Plan After Deductible	100%	80%
Manipulations:		
Co-pay Per Visit	\$5	Not Applicable
Paid By Plan After Deductible	100%	80%
X-rays:  Paid By Plan After Deductible	100%	80%
Contraceptive Methods And Counseling Approved	10070	5570
By The FDA (Applies To Calendar Year Maximums):	100%	80%
Paid By Plan After Deductible  Durable Medical Equipment (Applies To Calendar	100 /0	OU /0
Year Maximums):		
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):	\$5 100%	Not Applicable 80%
(Does Not Apply To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan	\$50 100%	\$50 100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):	\$50 100%	Not Applicable 80%
Nursing, Convalescent Or Subacute Facility (Does Not Apply To Calendar Year Maximums):  Maximum Days Per Spell Of Illness Paid By Plan After Deductible	150 100%	Days 100% (Deductible Waived)
General Anesthesia (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%
Home Health Care Benefits (Does Not Apply To Calendar Year Maximums): Included In Hospital Spell Of Illness Maximum (3 Visits Equal One Benefit Day) Paid By Plan	100%	100% (Deductible Waived)
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits (Does Not Apply To Calendar Year Maximums):		
Hospice Services:  • Paid By Plan	100%	100% (Deductible Waived)
Bereavement Counseling:  Paid By Plan	100%	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-admission Testing (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Services Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
<ul> <li>Maximum Days Per Spell Of Illness (Does Not Apply To Calendar Year Maximums)</li> </ul>	36	65
Paid By Plan	100%	80%
		1
After Maximum Is Satisfied (Applies To Calendar		
Year Maximums)  Paid By Plan After Deductible	80%	80%
1 and By Fight Anti-	0070	3070
Inpatient Physician Charges (Applies To Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Inpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Maximum Visits Per Period Of Confinement	1 Visit	Not Applicable
Paid By Plan After Deductible	100%	80%
Outpatient Services Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$5	
Paid By Plan After Deductible	100%	80%
Outpatient Physician Charges Only (Applies To Calendar Year Maximums)):		
Paid By Plan After Deductible	100%	80%
Outpatient Specialist Consultation (Applies To Calendar Year Maximums):		
Co-pay Per Exam	\$5	
Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Exam	\$5	9000
Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	<b>\$</b> 5	000/
Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgeon Charges Only (Applies To		
Calendar Year Maximums):		
Paid By Plan After Deductible	100%	80%
Infertility Treatment (Applies To Calendar Year		
Maximums):	Φ.Ε.	
Co-pay Per Visit	<b>\$</b> 5	000/
Paid By Plan After Deductible	100%	80%
Kidney Dialysis (Does Not Apply To Calendar Year Maximums):		
Hospital Expense Benefits:		
Co-pay Per Visit	\$5	
Paid By Plan	100%	80%
Office, Home (Medicare Certified), Or Free Standing Kidney Dialysis Facility Expense Benefits:  Paid By Plan	100%	100% (Deductible Waived)
Maternity (Applies To Calendar Year Maximums):		(Doddenbie Waited)
Paid By Plan After Deductible	100%	80%
Mental Health Benefits:		
Inpatient Or Partial Hospitalization: Included In Hospital Spell Of Illness Maximum  Maximum Days Per Calendar Year (Does Not Apply To Calendar Year Maximums)  Paid By Plan	120 100%	Days   100%   (Deductible Waived)
After Maximum Is Satisfied (Applies To Calendar Year Maximums)  Maximum Days Per Calendar Year	30.0	Days
Paid By Plan After Deductible	80%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment (Applies To Calendar Year Maximums):  • Maximum Benefit Per Visit  • Paid By Plan After Deductible	\$ <sup>,</sup> 100%	80%
Nursery And Newborn Expenses (Does Not Apply To Calendar Year Maximums):  • Maximum Benefit Per Admission  • Paid By Plan After Deductible	Not Applicable 100%	\$75 80%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar		
Year Maximums):	\$5	Not Applicable
<ul><li>Co-pay Per Visit</li><li>Paid By Plan After Deductible</li></ul>	ან 100%	Not Applicable 80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include (Does Not Apply To Calendar Year Maximums): From Age 19	10070	3070
Preventive / Routine Physical Exams At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:		No Benefit
From Age 35To Age 40  Maximum Exams From Age 40	1 Exam	
<ul> <li>Maximum Exams Per Calendar Year</li> <li>Paid By Plan</li> </ul>	1 Exam 100%	
Note: A Mammography With A Physician's Orders For Covered Persons, At Any Age, With A Personal Medical History Of Breast Cancer, Or Whose Mother Or Sister Has A History Of Breast Cancer.		
Preventive / Routine Pelvic Exams And Pap Test:  Maximum Exams Per Calendar Year  Paid By Plan	1 Exam 100%	No Benefit
Preventive / Routine Fecal Blood Culture:  Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
Paid By Plan	100%	80% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Paid By Plan	100%	
Preventive / Routine Hearing Exams:	4000/	000/
Paid By Plan	100%	80% (Deductible Waived)
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition:		
Paid By Plan	100%	80% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women:  > Gestational Diabetes		
<ul> <li>Papillomavirus DNA Testing</li> <li>Counseling For Sexually Transmitted Infections (Provided Annually)*</li> <li>Counseling For Human Immune-deficiency</li> </ul>		
Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling		
Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
Paid By Plan	100%	80% (Deductible Waived)
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums):		No Benefit
Preventive / Routine Physical Exams:		
Paid By Plan	100%	
Preventive / Routine Screenings At Appropriate Ages:		
Paid By Plan	100%	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Paid By Plan	100%	
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
Paid By Plan	100%	
Preventive / Routine Hearing Exam: Paid By Plan	100%	
	·	<del></del>

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing (Applies To Calendar Year		
Maximums):		
Paid By Plan After Deductible	100%	80%
Radiation Therapy:		
Hamital Billad Funances (Dass Not Apply To		
Hospital Billed Expenses (Does Not Apply To		
Calendar Year Maximums):	\$5	
<ul><li>Co-pay Per Visit</li><li>Paid By Plan</li></ul>	100%	80%
Paid By Plan	100 /6	00 /6
All Other Billed Expenses (Applies To Calendar		
Year Maximums):		
Co-pay Per Visit	\$5	Not Applicable
Paid By Plan After Deductible	100%	80%
Sterilizations (Applies To Calendar Year		
Maximums):	40001	000/
Paid By Plan After Deductible	100%	80%
Substance Abuse And Chemical Dependency		
Benefits (Applies To Calendar Year Maximums):		
Inpatient Or Partial Hospitalization:		
Maximum Benefit Per Calendar Year	7 W	eeks
Paid By Plan After Deductible	80%	80%
- Tala by Flam Allor Boadolible	3373	0070
Note: Two Days Of Partial Hospitalization Will		
Reduce Inpatient Maximum By One Day.		
Outpatient Treatment:	Φ.Ε.	Nico Acallada
Co-pay Per Visit	\$5	Not Applicable
Maximum Visits Per Calendar Year  Paid By Plan Affair Dadustible	100%	/isits   80%
Paid By Plan After Deductible	10076	0070
Note: 20 Of The Outpatient Treatment Visits May Be		
Used For Enrolled Family Member Counseling.		
Five Of The Twenty May Be Used Even If The		
Affected Family Member Is Not Receiving Care.		
Therapy Services:		
Occumptional Outpotions Hoonital And Office		
Occupational Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
7	\$5	Not Applicable
Co-pay Per Visit     Paid By Plan After Deductible	ან 100%	80%
Faid by Flatt After Deductible	(Deductible Waived)	00 /0
	(2000000000000)	
Physical Outpatient Hospital Therapy Within 6		
Months After Inpatient Hospital Stay For Related		
Surgery Or Illness And When Rendered Within 365		
Days After The Surgery Or In The Case Of Illness,		
After Hospital Discharge (Does Not Apply To		
Calendar Year Maximums):	ΦE	
Co-pay Per Visit     Daid By Plan After Deductible	\$5 100%	80%
Paid By Plan After Deductible	100%	OU70

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$5	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy Within 6 Months After Inpatient Hospital Stay For Related Surgery Or Illness And When Rendered Within 365 Days After The Surgery Or In The Case Of Illness, After Hospital Discharge (Does Not Apply To Calendar Year Maximums):		
Co-pay Per Visit	\$5	Not Applicable
Paid By Plan After Deductible	100%	80%
Physical Office Therapy After 6 Months Of Inpatient Stay (Applies To Calendar Year Maximums):  Co-pay Per Visit Paid By Plan After Deductible	\$5 100%	Not Applicable 80%
Speech Outpatient Hospital And Office Therapy (Applies To Calendar Year Maximums):		
Co-pay Per Visit	\$5	Not Applicable
Paid By Plan After Deductible	100%	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment (Applies To Calendar Year Maximums):	10070	3070
Maximum Benefit	1 \	l Vig
Maximum Benefit Per Lifetime		250
Paid By Plan After Deductible	100%	100% (Deductible Waived)
All Other Covered Expenses (Applies To Calendar Year Maximums):  Paid By Plan After Deductible	100%	80%

PRESCRIPTION SCHEDULE OF BENEFITS	
By Participating Retail Pharmacy	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	\$5 \$17.50 \$35.00 Same as above
<ul> <li>By Participating Mail Order Pharmacy</li> <li>Covered Person's Co-pay Amount Per Prescription Product</li> </ul>	For Up To A 90-Day Supply:
Generic Products Preferred Brand Products Non- Preferred Brand Products	\$10.00 \$35.00 \$70.00
By Specialty Pharmacy Vendor	
Covered Person's Co-pay Amount	For Up To A 30-Day Supply:
Generic Products Preferred Brand Products Non- Preferred Brand Products  By Non-Participating Pharmacy	\$10.00 \$35.00 \$70.00  Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To the Pharmacy Benefits Manager Identified In Appendix D For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.
For any Prescription Drug questions, please contact the Pharmacy Benefits Manager identified in <b>Appendix D</b> .	