APPENDIX B

MEDICAL SCHEDULES OF BENEFITS

MEDICAL SCHEDULE 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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	 For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	 For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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:		
• 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	 100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan **Preventive / Routine Screenings At Appropriate Ages:** • Paid By Plan **Preventive / Routine Diagnostic Tests, Lab And X-rays:** • Paid By Plan **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 **Preventive / Routine Hearing Exam:** • Paid By Plan	 100% 100% 100% 100% 100%	No Benefit

	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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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 and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
• Co-pay Per Visit	$27	
• Paid By Plan After Deductible	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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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 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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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 Health 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 Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Treatment:		
• Maximum Visits Per Calendar Year	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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 and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
• Co-pay Per Visit	$27	
• Paid By Plan After Deductible	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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $6 $18 $45 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $9 $27 $67.50
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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 and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
• Co-pay Per Visit	$27	
• Paid By Plan After Deductible	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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $6 $18 $45 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $9 $27 $67.50
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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 and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
• Co-pay Per Visit	$27	
• Paid By Plan After Deductible	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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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 and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
• Co-pay Per Visit	$27	
• Paid By Plan After Deductible	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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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 and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
• Co-pay Per Visit	$27	
• Paid By Plan After Deductible	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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

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 not considered to be Essential Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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 and Psychologists) (Applies To Calendar Year Maximums):		No Benefit
• Co-pay Per Visit	$27	
• Paid By Plan After Deductible	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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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 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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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)	$5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	 For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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 Generic Products Brand Products Non-Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Brand Products Non-Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Brand Products Non-Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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)	$6 $18 $45 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $9 $27 $67.50
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	 For Up To A 30-Day Supply: $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 **Appendix D**.	

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 not considered to be Essential Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $6 $18 $45 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $9 $27 $67.50
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	 For Up To A 30-Day Supply: $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 **Appendix D**.	

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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)	$5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	 For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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)	$5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	 For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$18	
• 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:		
• 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		
• 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	30 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%

	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$18	
• 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):		
Inpatient Or Partial Hospitalization:		
• Maximum Benefit Per Calendar Year	7 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	1 Wig	
• 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)	$5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	 For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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 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):		
• Co-pay Per Visit	$12	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$12	$12
• Paid By Plan After Deductible	100%	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	$12	$12
• 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):		
• Co-pay Per Visit	$12	$12
• 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	$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% (Deductible Waived)
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		
• 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	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 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):		
• Co-pay Per Visit	$12	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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 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 Weeks	
• 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	$12	Not Applicable
• Maximum Visits Per Calendar Year	60 Visits	
• 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	$12	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
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	$12	Not Applicable
• Paid By Plan After Deductible	100%	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	1 Wig	
• 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 Generic Products Brand Products Non-Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $0 $10.00 $20.00 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Brand Products Non-Brand Products	For Up To A 90-Day Supply: $0 $20.00 $40.00
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Brand Products Non-Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

MEDICAL SCHEDULE OF BENEFITS

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.

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 Health 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	60 Visits	
• 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 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%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$18	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$18	$18
• Paid By Plan After Deductible	100%	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	$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):		
• 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):		
• 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	
• 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%
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):		
• 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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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 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	$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):		
• 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 Weeks	
• 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	60 Visits	
• 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% (Deductible Waived)	80%
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	$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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

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 Health 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:		
• 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	60 Visits	
• 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 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 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):		
• Co-pay Per Visit	$12	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• Co-pay Per Visit	$12	
• 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	$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	
• 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):		
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		
• 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	30 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%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$12	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	
• Paid By Plan	100%	80%
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 Weeks	
• 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	$12	Not Applicable
• Maximum Visits Per Calendar Year	60 Visits	
• 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	$12	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
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	
• 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	$12	Not Applicable
• Paid By Plan After Deductible	100%	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	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 90-Day Supply: $10 $35 $70
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non-Preferred Brand Products	For Up To A 30-Day Supply: $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 **Appendix D**.	

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 not considered to be Essential Health 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	60 Visits	
• 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 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	$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 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):		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100%	80%
True Emergency Room / Emergency Physicians (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$50	$50
• Paid By Plan	100%	100% (Deductible Waived)
Non-true Emergency Room / Emergency Physicians (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$50	Not Applicable
• Paid By Plan After Deductible	100%	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	150 Days	
• Paid By Plan After Deductible	100%	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):		
• 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	
• Paid By Plan After Deductible	100%	80%
Outpatient Surgery Only (Does Not Apply To Calendar Year Maximums):		
• Co-pay Per Visit	$5	
• 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	$5	
• 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):		
• 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	
• 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%
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%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services (Applies To Calendar Year Maximums):		
• Co-pay Per Visit	$5	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	1 Exam	
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	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:		No Benefit
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100%	
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: • Paid By Plan	100%	No Benefit
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 ***These Services May Also Apply To Men.**	100%	80% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include (Does Not Apply To Calendar Year Maximums): **Preventive / Routine Physical Exams:** • Paid By Plan	100%	No Benefit
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	$5	
• Paid By Plan	100%	80%
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):		
• 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 Weeks	
• 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	$5	Not Applicable
• Maximum Visits Per Calendar Year	60 Visits	
• 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	$5	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
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	$5	
• 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	$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	$5	Not Applicable
• Paid By Plan After Deductible	100%	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):		
• Maximum Benefit	1 Wig	
• 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 Generic Products Preferred Brand Products Non-Preferred Brand Products Maintenance Products (initial fill only)	For Up To A 30-Day Supply: $5 $17.50 $35.00 Same as above
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products Preferred Brand Products Non- Preferred Brand Products	For Up To A 90-Day Supply: $10.00 $35.00 $70.00
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products Non- Preferred Brand Products	For Up To A 30-Day Supply: $10.00 $35.00 $70.00
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 **Appendix D**.	