MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 002, 003

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

Benefits listed in this Schedule of Benefits are subject to all provisions of the 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 Care 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, 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
Annual Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible.*** • Single Coverage • Family Coverage ***Note: If Family Coverage Is Elected, The Full Family Deductible Amount Must Be Met Before The Plan Will Begin Paying At The Plan Participation Level.***	$1400 $2800	$2800 $5600
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** • Single Coverage • Family Coverage – Individual "Embedded" Out-Of-Pocket ***Note: If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than His Or Her Embedded Individual Out-Of-Pocket Maximum Amount.***	$2800 $5600 $2800	$5600 $11,200 $5600
Acupuncture Treatment: • Maximum Visits Per Calendar Year • Paid By Plan After In-Network Deductible	6 Visits 80%	80%

	IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation: • Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps: • Paid By Plan After Deductible	100% (Deductible Waived)	60%
Contraceptive Methods And Contraceptive Counseling Approved By The FDA: **For Men:** • Paid By Plan After Deductible	80%	60%
For Women: • Paid By Plan After Deductible	100% (Deductible Waived)	60%
Durable Medical Equipment: • Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment: **Urgent Care:** • Paid By Plan After Deductible	80%	60%
True Emergency Room / Emergency Physicians: • Paid By Plan After In-Network Deductible	100%	100%
Non-True Emergency Room / Emergency Physicians: • Paid By Plan After Deductible	50%	50%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	120 Days 80%	60%
Home Health Care Benefits: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.***	120 Visits 80%	60%
Hospice Care Benefits: **Hospice Services:** • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	26 Weeks 80%	60%
Bereavement Counseling: • Paid By Plan After Deductible	80%	60%
Hospital Services: **Pre-Admission Testing:** • Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate: • Paid By Plan After In-Network Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Services / Outpatient Physician Charges: • Paid By Plan After Deductible	80%	60%
Outpatient Imaging Charges: • Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges: • Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges: • Paid By Plan After Deductible	80%	60%
Manipulations: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	12 Visits 80%	60%
Maternity: **Routine Prenatal Services:** • Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery, And Postnatal Care: • Paid By Plan After Deductible	80%	60%
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: • Paid By Plan After Deductible	80%	60%
Morbid Obesity Treatment: • Paid By Plan After Deductible	80%	60%
Bariatric Surgery: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	1 Surgery 80%	60%
Nursery And Newborn Expenses: • Paid By Plan After Deductible ***Note: Deductible And / Or Co-pay Will Be Waived For Preventive/Routine Well Newborn Charges, Initial Stay (Days 0-5).***	80%	60%
Physician Office Visit: • Paid By Plan After Deductible	80%	60%
Physician Office Services: • Paid By Plan After Deductible	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Immunizations:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Pelvic Exams And Pap Tests:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Autism Screening: From Age 0 To 21		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Hearing Exams:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Treatment For 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 After Deductible ***These Services May Also Apply To Men.**	100% (Deductible Waived)	60%
Sterilizations: **For Men:** • Paid By Plan After Deductible	Not Covered	Not Covered
For Women: • Paid By Plan After Deductible	100% (Deductible Waived)	60%
Teladoc Services: • Paid By Plan After Deductible	80%	
Temporomandibular Joint Disorder Benefits: • Paid By Plan After Deductible	80%	60%
Therapy Services: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible ***Note: Medical Necessity Will Be Reviewed After 25 Visits.***	60 Visits 80%	60%
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	$500 80%	80%
All Other Covered Expenses: • Paid By Plan After Deductible	80%	60%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) ALL		
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible **Travel And Housing:** • Maximum Benefit Per Day • Paid By Plan After Deductible ***Note: Maximum Benefit Per Day Applies To Transportation, Lodging And Meals.*** Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	 80% $200 100%	
	IN-NETWORK	**OUT-OF-NETWORK**
Transplant Services At A Non-Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	 60%	 60%