

MEDICAL SCHEDULE OF BENEFITS- SIGNATURE COPAY OPTION

	PARTICIPATING PROVIDER (Subject to the Allowed Amount)	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount)
CALENDAR YEAR DEDUCTIBLE		
Individual	Not Applicable	\$200
Individual + Dependent(s)	Not Applicable	\$400
Family	Not Applicable	\$600
If you have two-person or family coverage, each person within a family must satisfy the individual Deductible listed above before any expenses (unless otherwise stated in this Schedule of Benefits) will be Covered by the Plan for that person in the Calendar Year; however, any combination of family members may satisfy the two-person or family Deductible.		
CALENDAR YEAR OUT-OF-POCKET LIMIT		
Individual	\$1,000	\$1,000
Individual + Dependent(s)	\$2,000	\$2,000
Family	\$3,000	\$3,000
If you use a combination of Participating Providers and Non-Participating Providers, your Out-of-Pocket Limits are separate amounts and are not combined. This means that you will be required to satisfy the Out-of-Pocket Limit amount for Participating Providers and Non-Participating Providers separately. The amounts you pay towards satisfaction of the Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit and the amounts you pay towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Participating Provider Out-of-Pocket Limit.		

MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Advanced Imaging Services (Outpatient) (MRI, PET scans, CT scans, and nuclear medicine)		
Facility services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Allergy Services		
Testing	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Treatment (including serum)	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible

MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Ambulance Services Pre-hospital emergency services	\$20 Copayment	40% Coinsurance, after the Deductible
Transportation Ground ambulance	\$20 Copayment	40% Coinsurance, after the Deductible
Air ambulance	\$20 Copayment	40% Coinsurance, after the Deductible
Water ambulance	\$20 Copayment	40% Coinsurance, after the Deductible
Inter hospital transportation	\$20 Copayment	40% Coinsurance, after the Deductible
Ambulatory Surgical Center		
Facility services	\$20 Copayment	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Anesthesia Services (all settings)	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Breast Pump	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Benefit limitation	Limited to one (1) rental or purchase per pregnancy resulting in a live birth. (Participating Providers and Non-Participating Providers combined)	
Cardiac and Pulmonary Rehabilitation (Outpatient)		
Facility services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Chemotherapy (Outpatient)		
Facility services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible

MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Chiropractic Care	\$20 Copayment	40% Coinsurance, after the Deductible
Calendar Year maximum	20 visits (Participating Providers and Non-Participating Providers combined)	
Colonoscopies (Diagnostic)		
Facility services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Dental Oral Surgery	\$20 Copayment	40% Coinsurance, after the Deductible
Dialysis (Outpatient)		
Facility services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Durable Medical Equipment	\$20 Copayment*	40% Coinsurance, after the Deductible
Supplies	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
*Note: For rental of Durable Medical Equipment, the Copayment will apply only once per Calendar Year or once per course of treatment, whichever is less.		
Emergency Services		
<i>Emergency Condition</i>		
Facility services	\$50 Copayment*	\$50 Copayment*
Professional services	0% Coinsurance, not subject to Deductible	0% Coinsurance, not subject to Deductible
<i>Non-Emergency Condition</i>		
Facility services	\$100 Copayment	\$100 Copayment
Professional services	0% Coinsurance, not subject to Deductible	0% Coinsurance, not subject to Deductible
Foot Orthotics	\$20 Copayment	40% Coinsurance, after the Deductible
Hearing Evaluations (Diagnostic)	\$20 Copayment	40% Coinsurance, after the Deductible
Home Care	\$20 Copayment	40% Coinsurance, after the Deductible
Calendar Year maximum	60 visits (Participating Providers and Non-Participating Providers combined)	
Home Infusion Therapy	\$20 Copayment	40% Coinsurance, after Deductible
Hospice Care	0% Coinsurance, not subject to	40% Coinsurance, after the

MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Inpatient	Deductible	Deductible
Lifetime maximum	210 days (Participating Providers and Non-Participating Providers combined)	
Outpatient	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Lifetime maximum	210 days (Participating Providers and Non-Participating Providers combined)	
Bereavement Counseling	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Calendar Year maximum	5 visits (Participating Providers and Non-Participating Providers combined)	
Inpatient Hospital Services		
Facility services	\$100 Copayment	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Lab and Pathology (Outpatient)		
<i>Professional services</i>		
Diagnostic	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Routine	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
<i>Facility services</i>		
Diagnostic	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Routine	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Mammograms (Diagnostic)	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Maternity Care (Professional Services)		
Initial visit (diagnosis)	\$20 Copayment	40% Coinsurance, after the Deductible
Prenatal/postnatal care that is a Preventive Service	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Prenatal/postnatal care that is not a Preventive Service	0% Coinsurance not subject to Deductible	40% Coinsurance, after the Deductible

MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Delivery (physician or midwife)	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Medical Supplies	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Mental Health and Substance Use Services		
Inpatient services	\$100 Copayment	40% Coinsurance, after the Deductible
Outpatient services	\$20 Copayment	40% Coinsurance, after the Deductible
Newborn Nursery Care – Routine		
Facility services	\$100 Copayment	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Observation Stays	\$100 Copayment	40% Coinsurance, after the Deductible
Orthotics	\$20 Copayment	40% Coinsurance, after the Deductible
Office Visits	\$20 Copayment	40% Coinsurance, after the Deductible
Physical Rehabilitation - (Inpatient)		
Facility services	\$100 Copayment	40% Coinsurance, after the Deductible
Calendar Year maximum	60 days (Participating Providers and Non-Participating Providers combined)	
Preadmission Testing	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Preventive Care		
Adult annual physical examinations	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Calendar Year maximum	1 exam (Participating Providers and Non-Participating Providers combined)	
Adult immunizations	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Bone density testing	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Colonoscopies	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible

MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Gynecological services/well woman exams	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Mammograms	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Elective sterilization		
Female	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Male	Subject to applicable Cost-Sharing based on Covered service provided	Subject to applicable Cost-Sharing based on Covered service provided
Prostate cancer screenings	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Well child visits and immunizations	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Preventive Care that is considered a Preventive Service	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Preventive Care that is not considered a Preventive Service	Cost-Sharing is based on applicable service being provided	40% Coinsurance, after the Deductible
Prosthetic Devices		
External	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Implanted	\$100 Copayment	40% Coinsurance, after the Deductible
PUVA Treatment	\$20 Copayment	40% Coinsurance, after the Deductible
Radiation Therapy (Outpatient)		
Facility services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Rehabilitation/Habilitation Services (Outpatient) (Physical therapy)		
Facility services	\$20 Copayment	40% Coinsurance, after the Deductible
Professional services	\$20 Copayment	40% Coinsurance, after the Deductible

MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Calendar Year maximum	32 visits (Participating Providers and Non-Participating Providers combined)	
Skilled Nursing Facility	\$100 Copayment	40% Coinsurance, after the Deductible
Surgical Procedures		
Inpatient		
Facility services	\$100 Copayment	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Outpatient		
Facility services	\$20 Copayment	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Office surgery	\$20 Copayment	40% Coinsurance, after the Deductible
Telemedicine Program – MD Live	\$10 Copayment	Not Covered
Treatment of Diabetes		
Insulin and supplies	0% Coinsurance, not subject to Deductible Insulin and supplies available at a retail or mail order Participating Pharmacy	40% Coinsurance, Subject to Deductible Insulin and supplies available at a retail or mail order Participating Pharmacy
Benefit maximum	Limited to a 90-day supply from a retail Participating Pharmacy or a 90-day supply from a mail order Participating Pharmacy. In addition to the above, for Retirees, any Cost-Sharing required under the Medicare Part B or any diabetic supplies not Covered under Medicare Part B are covered at 0% Coinsurance, not subject to Deductible.	
Diabetic education	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Diabetic equipment	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Urgent Care Center		
Facility services	\$20 Copayment	40% Coinsurance, after the Deductible
Professional services	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible

MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Vision Care (Diagnostic Eye Exams)	\$20 Copayment	40% Coinsurance, after the Deductible
X-Rays (Outpatient)		
<i>Facility services</i>		
Diagnostic	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Routine	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
<i>Professional services</i>		
Diagnostic	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible
Routine	0% Coinsurance, not subject to Deductible	40% Coinsurance, after the Deductible