

Health Care Benefit Chart

Issued & Underwritten by
McKinley Life Insurance Company

**BENEFIT RECIPIENT
(RETIREE PLAN)**



NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

*Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please contact your Employer or call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.

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Benefits* Chart

This Benefits Chart (also called "Schedule of Benefits") is part of Your Certificate. It explains Your specific Coverage and Benefits, including what You need to pay, what We will pay, and the Limitations and Exclusions in the Group Policy between Your Employer and AultCare.

If You have questions, please call AultCare's Service Center at (330) 363-6360 or 1-800-344-8858. You also can email Us at www.aultcare.com.

I. DESCRIPTION OF REQUIREMENTS AND TERMS UNDER THE MASTER GROUP POLICY BETWEEN YOUR EMPLOYER AND MCKINLEY LIFE INSURANCE COMPANY

Your Eligibility Requirements

- A Dependent Child will remain eligible until the end of the month in which the Child reaches age 18 unless the Child is a Full-time Student or has a physical or mental handicap providing proof of disability is given before the limiting age of 18.
- Full-time Student means the Child is under the age of [22] and is taking the minimum number of hours per semester at a college, university, or trade school. Coverage will cease at the end of the month the Child attains age [22]. The Student also must be unmarried and must depend on You for sole support.
- [For Retirees retired prior to [date]:] [For Retirees retired after [date]:]
- [Benefit Recipient means a member who is receiving a disability benefit or a person who, as the result of the death of a member, contributor, or retiree, qualifies for or are receiving some right or benefit, and You meet the following, applicable conditions:
 - [You receive a monthly benefit check from [Group Name], and you qualify for health care benefits; and]
 - [You reside in a geographic area in Ohio in which there are Network Care Providers.]
- [If both spouses are Benefit Recipients insured under the Master Group Policy, only children may be insured as Dependents and only one of the spouses may carry Dependent coverage.]
- [Retired Employee means that You were on Your Employer's W-2 Payroll before Your retirement, [are [not] subject to a [collective] bargaining agreement,] [as an eligible active employee on the date of []] You have reached the qualifying retirement age [(48-64)], and You meet the following, applicable conditions:
 - [You must be receiving [or eligible to receive] a pension and such pension is paid to you based on Your employment with Employer/Local Union;]
 - [You are a [Partner] within the [company;]

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- [You have had [at least (5-30) years of] active employment [or service credit] with the Employer immediately prior to retirement;]
- [You have been insured under the Employer's/Local Union's Plan [for (2-5) years] immediately prior to retirement;]
- [You must reside in a geographic area in Ohio in which there are Network Care Providers. Once you waive coverage for any reason, you may not elect back in to the Plan, unless you apply for health care coverage within thirty-one (31) days of attaining age sixty-five (65); or within thirty-one (31) days of the date coverage involuntarily terminated under another group plan, and with proof of such termination provided to [Group Name].]
- [You must be enrolled in Medicare Part A and Part B when you become eligible for Medicare coverage. Your eligible spouse must be enrolled in Medicare Part A and Part B when such spouse becomes eligible for Medicare coverage;]
- [The required contribution is made by the Local Union.]
- [have completed at least [5-25] consecutive years of service with [Group Name] or [5-25] consecutive years of service with a combination of [Group Name] service [with consecutive service time acquired in any of the four pre-merger groups.]]
- [Retired Employee eligible to commence or receiving an early, normal or late retirement benefit under the terms of the Company, and covered under one of the Hospital's Medical Plans immediately preceding retirement or; if you were an Employee who meets the criteria specified in this prior acceptance (but not eligible for the retirement benefit), or if you are eligible for Disability Retirement Benefits and elect COBRA Medical coverage which remains in effect, unless terminated solely due to Medicare entitlement, up to the date you become eligible to commence an early or normal retirement benefit. Upon retirement, you may only elect the Medical Plan option you were enrolled in immediately prior to retirement. You can only change medical plan options if you move out of a covered HMO area (qualifying event) or at the annual Open Enrollment. Once you waive coverage for any reason, you may not elect back in to the Plan.]

[The Employer will supply an eligibility list for all eligible Retired Employees. If You are on that list and the required contribution is paid to the Fund, You will be eligible to participate in the Plan for the period covered by the premium payment and eligibility list.]

It is Your responsibility to:

- Enroll in this Plan when You retire from Your Employer;
- [File a written application within thirty days from the date Your eligibility as an Active Employee ceases; the month immediately following the month You had sufficient bank hours,]
- [pay (% of) the cost of the health insurance under this Plan.]

[Your Coverage under this Plan will end when:]

- [You become employed with a new employer and eligible for coverage with the new employer.]
- [You become [[65] years of age], [Medicare primary], or [Medicare eligible], whichever event comes first.]

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- [Enroll in this Plan, filing a written application within thirty days from the date Your eligibility as an Active Employee ceases, when You retire from Your Employer;]
 - [You reach the date you become Medicare eligible or the date satisfying the completion of 36 months on this plan, whichever event comes first.]
 - [You are a member of [Senior Management.]]
- [[Spouse of a Retiree means a legal Spouse, who (is/is not)] eligible for this Plan when a previously eligible Retired Employee no longer is eligible for Coverage.]
 - [If Your Spouse is younger than You, Coverage for Your Spouse will end on the same date as Your Coverage;]
 - [Spousal coverage is limited to 36 months, or upon becoming eligible for Medicare, whichever event comes first.]
 - [Spouse [remarries], [or becomes insured under another group insurance plan] [as a result of the employment of such spouse]
 - [Eligible dependents may continue coverage as long as retiree is covered. Eligible dependents may also elect to continue coverage upon death of the retiree.]]

[When You retire from Your Employer, it is Your responsibility to enroll your Spouse and Dependents in this Plan.]

- [You will not have benefits for Your spouse;]
- [You will not have benefits for Your children;]

[Your Spouse, if participating at time of Your [retirement] [remarriage, or becomes insured under another group insurance plan as a result of the employment of such spouse] may continue until Medicare eligible.]

[Your Dependents will be Covered until they cease to be eligible under the guidelines of this Plan.]]

Your Waiting Period

Coverage begins on the latest to occur of: the effective date of your monthly benefit, or first of the month following receipt of the retirement application; or first of the month following SERS' approval of your application for disability benefits.

- Your Coverage will be Effective after You apply for Coverage and agree in writing to pay the required Contributions. Coverage will begin on the first day of the month following the day You become eligible, unless Your Employer has a Waiting Period.
- If you are covered under Special Enrollment, coverage will begin on the day of the Triggering Event, provided that You apply for Coverage and agree in writing to pay the required Contributions within the Special Enrollment period
- If you are a Late Applicant (See Section 41) coverage will begin on the first day of the month following the day You apply for Coverage and agree in writing to pay the required Contributions.

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Your Employer's Enrollment Periods

- Initial Enrollment Period runs for 31 days beginning on date of retirement.
- You will not have a Pre-Existing Medical Condition Exclusionary period.
- Special Dependent Enrollment runs for 31 days, beginning on the Triggering Event, such as marriage, birth, adoption, or placement for adoption. Newborns are covered for 31 days from date of birth.
- Special Enrollment runs for 31 days, beginning on the Triggering Event, such as marriage, birth, adoption, or placement for adoption.

Your Coverage Ends

Your Coverage will end at the earliest of:

1. The date coverage ends for everyone under the terms of Your Employer's Master Group Policy.
2. The end of the period for which the last Premium has been paid for You;
3. The date Your Employer's Master Group Policy ends;
4. The end of the period for which You made the last contribution;
5. The last day of the Coverage Month in which You request termination, but not prior to the date of the request;
6. The last day of the Coverage Month in which You retire or get Your pension (unless the Benefits Chart includes a specific classification for retired or pensioned Persons);
7. The last day of the Coverage Month in which You enter active military service for any country, except for temporary duty of 30 days or less, or when a reservist is ordered to active duty, as provided by Ohio law.

Your Dependent's Coverage Ends:

Dependent Coverage will end at the earliest of:

1. The date Your Coverage ends;
2. The date Dependent Coverage ends under the Master Group Plan;
3. The last day of the Coverage Month during which the Person ceases to be a Dependent;
4. The end of the period for which the last Premium has been paid for the Dependent;
5. The end of the period for which the last Contribution was made by You for Your Dependent;

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6. The date the Master Group Policy is terminated;
7. The last day of the Coverage Month in which the Dependent becomes a member.
8. Discharge from the hospital for episode of care.

Continuation of Coverage For Your Surviving Dependents After Your Death

If you die while covered under any part of this Plan, any Health Expense Coverage then in force for your dependents may be continued, subject to determination by SERS.

Any dependent's coverage, including your spouse's, will cease when any one of the following happens:

1. A dependent ceases to be a defined dependent.
2. A dependent becomes eligible for like coverage under this Plan.
3. Dependent coverage ceases as to the Eligible Class of which you were a member right before your death.
4. Any required contributions cease.

If Health Expense Coverage is being continued for your dependents, your child born after your death will also be covered.

Maximum Time to Submit a Claim

The maximum time in which to submit a claim in order for it to be processed is 24 months.

INTEGRATION WITH MEDICARE

This section applies to the following Benefit Recipients and Dependents who are covered or are eligible to enroll and be covered under Part A and Part B of Title XVIII of the Social Security Act, as amended (Medicare):

- Retired employees and their Dependents but only if medical coverage is provided for retired employees and their Dependents.
- Active, full-time employees, if any, and their Dependents, age seventy (70) or older; and
- Active, full-time employees, if any, and their Dependents, age sixty-five (65) through sixty-nine (69) who are not affected by the Tax Equity and Financial Responsibility Act (TEFRA).

Definitions:

"CLAIM DETERMINATION PERIOD" means a Calendar Year or that portion of a calendar year during which a Benefit Recipient or insured Dependent is eligible to receive benefits.

Amount of Benefits:

The benefits payable under this policy this during any Claim Determination Period with respect to any treatment rendered or services and supplies furnished to such Benefit Recipient or Dependent will be equal to the difference between:

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- a. the dollar amount of benefits that would have been paid under this policy if the Benefit Recipient or Dependent had not become eligible for Medicare; and
- b. the dollar amount payable under both Part A and Part B of Medicare.

Benefits payable under Part A and Part B of Medicare include benefits which would have been payable if claim had been duly made.

Any Benefit Recipient or Dependent claiming benefits under this policy must furnish the Company information necessary to implement and apply this provision.

The Company has the right, in its discretion, to pay over to any organization any amounts required to satisfy the intent of this provision. Amounts so paid are considered benefits paid under this policy and, to the extent of such payments, the Company shall be fully discharged from liability.

Whenever payments have been made by the Company in excess of the maximum amount required to satisfy the intent of this provision, The Company has the right to recover any excess payments from any individual or organization to whom such payments were made.

Effect On Other Policy Provisions:

The term "Plan" as used in the Coordination of Benefits Provision of this policy does not include Medicare.

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II. BENEFIT LEVELS UNDER THE GROUP POLICY BETWEEN YOUR EMPLOYER AND MCKINLEY LIFE INSURANCE COMPANY

The level of Benefits* You receive under Your Employer's Group Policy, and the amount You must pay Out-of-Pocket, depend on whether You receive medical services from Network Providers. You usually will need to pay more Out-of-Pocket if You go to a Non-Network Provider.

Policy Provision	Network Provider	Non-Network Provider
Co-pay: The set dollar amount You pay Out-of-Pocket for each Doctor Office Visit. The co-pay does not count against Your Annual Deductible. Application of Copay is dependent upon services rendered.	[\$0-\$75] [Primary Care Physician] [[[\$0-\$75] [Specialist]] [\$5-\$150] [ER]/[Outpatient] Facility [\$20-\$85] Urgent Care	[\$0-\$75] [Primary Care Physician] [[[\$0-\$75] [Specialist]] [\$5-\$150] [ER]/[Outpatient] Facility [\$20-\$85] Urgent Care
Annual Deductible: The minimum amount You must pay Out-of-Pocket each year before Benefits are paid under the Policy.	[\$0 - \$5,000 for an individual] [\$0- \$10,000 for a family] [Services rendered at [Facility Name]] [\$0 - \$5,000 for an individual] [\$0- \$10,000 for a family]	[\$0-\$7,500 for an individual] [\$200- \$15,000 for a family]
Co-insurance (Out-of-Pocket Expense): This is the percentage of medical expense You share with the Policy after You meet Your Annual Deductible and Co-pay.	[Your share of the charge 0%-30%]	[Your share of the charge 0%-50%] plus any charges in excess of UCR
Annual Out-of-Pocket Maximum (Annual Max): This is the total amount You pay Out-of-Pocket in one Year before the Policy pays 100% of Your medical expenses. It does not include Your Deductible. It does not include Co-payments.	[\$0 - \$5,000 per individual] [\$0 - \$10,000 per family] [Services rendered at [Group Name]] [\$0 - \$5,000 for an individual] [\$0- \$10,000 for a family] Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% except for penalties, benefits paid at 50%, and [non-emergency care] which are not included in the 100% reimbursement provision.	[\$300 - \$10,000 per individual] [\$0 - \$20,000 per family] [Unlimited] Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% except for penalties, benefits paid at 50%, and [non-emergency care] which are not included in the 100% reimbursement provision.
Lifetime Maximum [\$1,000/\$2,000 reinstatement]	[\$7,500 - \$5,000,000] [Unlimited]	[\$7,500 - \$5,000,000] [Unlimited]
Penalty If You Do Not Get Pre-Approval		50% up to \$500 to Enrollee

Note: If You use Non-Network Providers, only what is paid up to UCR will count toward Your Deductible. Your Deductible and out-of-pocket expenses for Non-Network Providers may be separate from Network Providers.

BENEFIT LIMITATIONS MAY APPLY

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III. COVERED BENEFITS (SERVICES) UNDER YOUR EMPLOYER'S GROUP POLICY*

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Allergy Extract	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
Allergy Injections	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
Allergy Testing	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
Anesthesia In Office	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Anesthesia Outpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Anesthesia Inpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Bio-Feedback In Office (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Bio-Feedback Outpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Bio-Feedback Inpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Cardiac Rehabilitation I & II Outpatient Cardiac Rehab III not covered	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Cardiac Rehabilitation I & II Inpatient Cardiac Rehab III not covered	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Chemo/Radiation Therapy In Office	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Chemo/Radiation Therapy Outpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Chemo/Radiation Therapy Inpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Dialysis In Office	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Dialysis Outpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Dialysis Inpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Infertility Testing In Office (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Infertility Testing Outpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Infertility Testing Inpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Infertility Treatment In Office (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Infertility Treatment Outpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Infertility Treatment Inpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Injections (Medical) In Office Not including routine immunizations	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Injections (Medical) Outpatient Not including routine Immunizations	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Injections (Medical) Inpatient Not including routine Immunizations	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Inpatient Hospital Admission (Semi-Private room)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Inpatient Hospital Physician	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Laboratory/X-Ray/Diagnostic In Office	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Laboratory/X-Ray/Diagnostic Outpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Laboratory/X-Ray/Diagnostic Inpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Mammography (Medical Diagnosis) In Office	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Mammography (Medical Diagnosis) Outpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Mammography (Medical Diagnosis) Inpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Maternity Enrollee/Spouse Ultrasounds covered when Medically Necessary	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Maternity Dependent Care The Dependent's Newborn coverage is not provided unless newborn is dependent upon retiree and lives with retiree in parent-child relationship	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Occupational Therapy In Office Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Occupational Therapy Outpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Occupational Therapy Inpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Office Visit Illness	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Office Visit Injury	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Organ Donor Coverage	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Organ Transplant Coverage (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Physical Therapy In Office Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Physical Therapy Outpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Physical Therapy Inpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Pre-Admission Testing	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Prescription Drugs Administered in Office	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Rehabilitation Services In Office Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Rehabilitation Services Inpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Rehabilitation Services Outpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Respiratory Therapy In Office	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Respiratory Therapy Outpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Respiratory Therapy Inpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Speech Therapy In Office Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Speech Therapy Inpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Speech Therapy Outpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Surgery In Office	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Surgery Outpatient (Sameday)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Surgery Inpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Surgery Assistant Surgeon Outpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Surgery Assistant Surgeon Inpatient	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Surgery Cosmetic/Reconstructive	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Surgery Second Surgical Opinion	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Emergency and Urgent Care	Network Provider	Non-Network Provider
Emergency Care Approved Emergency (See Definition of Emergency Services)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Non-Emergency (See Definition of Emergency Services)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Emergency Care Out of Service Area	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Urgent Care	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Emergency and Urgent Care	Network Provider	Non-Network Provider
Urgent Care Non-Approved	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
<p>Mental Health Outpatient</p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>Mental Health Inpatient</p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>Mental Health Outpatient Treatment Programs</p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

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Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Alcohol/Substance Abuse Outpatient With Plan Approval, services are paid the same as treatment for other physical illness or injury.	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Alcohol/Substance Abuse Inpatient With Plan Approval, services are paid the same as treatment for other physical illness or injury.	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Alcohol/Substance Abuse Outpatient Treatment Programs With Plan Approval, services are paid the same as treatment for other physical illness or injury.	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Other Services	Network Provider	Non-Network Provider
Abortion Therapeutic	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Ambulance	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Attention Deficit Disorder (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Bariatric Surgery (Plan Approval Required) For surgery when morbidly obese with severe health conditions AND documented history of repeated failure of physician supervised medical/dietary therapies	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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BB

Other Services	Network Provider	Non-Network Provider
Blood Replacement Programs (Blood not replaced)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Breast Prosthesis/Bra Initial Replacement prosthesis is covered if Medically Necessary Replacement bra is covered	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Durable Medical Equipment (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Genetic Counseling (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Other Services	Network Provider	Non-Network Provider
[Growth Hormone Treatment]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Hepatitis Vaccination High Risk	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Home Health Care (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Hospice Care (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Other Services	Network Provider	Non-Network Provider
Pain Management (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Private Duty Nursing (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Psychological/Personality Testing	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Skilled Nursing (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Other Services	Network Provider	Non-Network Provider
[Smoking Cessation]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Sterilization]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Temporomandibular Joint Dysfunction (TMJ)] (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Educational Training	Network Provider	Non-Network Provider
Diabetic Education Outpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Diabetic Education Inpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Educational Training Outpatient Medically Necessary	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Educational Training Inpatient Medically Necessary	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Educational Training	Network Provider	Non-Network Provider
[Nutritional Counseling Outpatient] Medically Necessary	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Nutritional Counseling Inpatient] Medically Necessary	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Preventive Care	Network Provider	Non-Network Provider
Breast Reconstructive Surgery after Mastectomy	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Colonoscopy]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Gynecological Exam]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Gynecological Pap Test	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Preventive Care	Network Provider	Non-Network Provider
<p>[Immunizations Beyond Well Child Care]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>Mammography (Routine Screening)</p> <p>Coinsurance is applied to 130% of the Reimbursed Medicare Amount. The total benefit for a screening mammography shall not exceed 130% of the Reimbursed Medicare Amount. Amount shall constitute payment in full.</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>[Physical (Routine)]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>Ultrasound (Routine Maternity)</p> <p>See Maternity Enrollee/Spouse</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

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Preventive Care	Network Provider	Non-Network Provider
<p>Well Child Care (Hearing Screening included for age 0-12 months, benefit not to exceed \$75)</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

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Affiliate Providers	Network Provider	Non-Network Provider
Chiropractic Coverage Office Visit	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Chiropractic Coverage Other Services	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Chiropractic Coverage Diagnostic Testing	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Massotherapy]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Affiliate Providers	Network Provider	Non-Network Provider
Podiatry Coverage Office Visit	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Podiatry Coverage Diagnostic/Testing	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Podiatry Coverage Surgery	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Podiatry Coverage Other Services	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0] <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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