Health Care Benefit Chart

Issued & Underwritten by

AultCare Insurance Company

STATE TEACHERS RETIREMENT SYSTEM OF OHIO
NON-MEDICARE
950010
JANUARY 1, 2021

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 Retirement System or call the AultCare Service Center 330-363-6360 or 1-800-344-8858.

AIC Benefit Recipient Benefits Chart 2021

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AIC Benefit Recipient Benefits Chart 2021

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AIC Benefit Recipient Benefits Chart 2021

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 Retirement System and AultCare.

If You have questions, please call the AultCare Service Center at 330-363-6360 or 1-800-344-8858. You can also visit our website at www.aultcare.com.

I. BENEFIT LEVELS UNDER THE GROUP POLICY BETWEEN YOUR RETIREMENT SYSTEM AND AULTCARE INSURANCE COMPANY

Policy Provision	Network Provider	Non-Network Provider
Copayment: The set dollar amount You pay Out-of-Pocket for each Doctor Office Visit	$20 Primary Care Physician $20 Telemedicine Primary Care Physician $40 Urgent Care $150 ER Facility	$40 Urgent Care $150 ER Facility
Annual Deductible: The minimum amount You must pay Out-of-Pocket each year before Benefits are paid under the Policy. Your Plan has an Non-Integrated Deductible	$2,500 for an Individual	$5,000 for an individual
Coinsurance (Out-of-Pocket Expense): This is the percentage of medical expense You share with the Policy after You meet Your **Annual Deductible** and **Copayment**.	Your share of the charge 20%	Your share of the charge 50% RBP plus any charges in excess of RBP
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 include Your Deductible and Copayments. Your Plan has a Non-Integrated Out-of-Pocket.	$6,500 per individual	$13,000 per individual

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

If You use Non-Network Providers, only what is paid up to RBP will count toward Your Deductible. Your Deductible and Out-of-Pocket expenses for Non-Network Providers may be separate from Network Providers.

Non-Integrated means Network and Non-Network Deductibles do not accumulate towards each other.

DEDUCTIBLE CARRYOVER means any expenses that track toward the individual Deductible for claims incurred in the last three (3) months of a Calendar Year will also track toward the individual Deductible for the next Calendar Year.

II. COVERED BENEFITS (SERVICES) UNDER YOUR RETIREMENT PLAN'S GROUP POLICY

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Allergy Extract	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Allergy Injections	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Allergy Testing	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Anesthesia **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Anesthesia **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Anesthesia **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Biofeedback In Office	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Biofeedback Outpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Biofeedback Inpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Cardiac Rehabilitation Phase I Inpatient **Cardiac Rehab III not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Cardiac Rehabilitation Phase II Outpatient **Cardiac Rehab III not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Chemo/Radiation Therapy **Outpatient** **Please note that orally administered cancer medication Coverage shall be no less favorable than Coverage for intravenous and injected cancer medications in accordance with state law**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Chemo/Radiation Therapy Inpatient **Please note that orally administered cancer medication Coverage shall be no less favorable than Coverage for intravenous and injected cancer medications in accordance with state law**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Chemo/Radiation Therapy In Office **Please note that orally administered cancer medication Coverage shall be no less favorable than Coverage for intravenous and injected cancer medications in accordance with state law**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Dialysis **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Dialysis **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Dialysis **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Infertility Testing In Office	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Infertility Testing Outpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Infertility Testing Inpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Infertility Treatment In Office **Plan Approval Required** **Meds limited to 3 ovulation cycles per pregnancy** **Artificial Insemination and In Vitro are not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Infertility Treatment Outpatient **Plan Approval Required** **Meds limited to 3 ovulation cycles per pregnancy** **Artificial Insemination and In Vitro are not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Infertility Treatment Inpatient **Plan Approval Required** **Meds limited to 3 ovulation cycles per pregnancy** **Artificial Insemination and In Vitro are not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Injections (Medical) In Office **Not including routine Immunizations**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Injections (Medical) Outpatient **Not including routine Immunizations**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Injections (Medical) Inpatient **Not including routine Immunizations**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Inpatient Hospital Admission	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Inpatient Hospital Physician	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Laboratory/X-Ray/Diagnostic **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Laboratory/X-Ray/Diagnostic Outpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Laboratory/X-Ray/Diagnostic Inpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Mammography **(Medical Diagnosis)** **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Mammography (Medical Diagnosis) Outpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Mammography (Medical Diagnosis) Inpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Maternity	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Ultrasound Maternity **Must be Medically Necessary**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Occupational Therapy **In Office** **Illness or injury related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Occupational Therapy Outpatient **Illness or injury related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Occupational Therapy Inpatient **Illness or injury related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Office Visit Primary Care Physician **Illness/Injury** **Copayment applies to the first two Network Primary Care Physician visits, then Coinsurance and Deductible apply**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Office Visit Specialist **Includes Telemedicine for Dermatology**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Telemedicine	You Must Pay: Copayment Applies After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Organ Donor Coverage **Plan Approval Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Organ Transplant Coverage **Prior Authorization Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Physical Therapy **In Office** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Physical Therapy **In Outpatient** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Physical Therapy **Inpatient** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Autism Spectrum Disorder **20 visits each service, each year, Physical Rehabilitation Services, Speech & Language and/or Occupational Therapy** **Mental/Behavioral health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans** **20 hours per week, therapies supported by empirical evidence, which includes and not limited to Applied Behavioral Analysis**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Pre-Admission Testing	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Prescription Drugs **Administered in Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Respiratory Therapy **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Respiratory Therapy Outpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Respiratory Therapy Inpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Speech Therapy **In Office** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Speech Therapy Inpatient **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Speech Therapy Outpatient **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Surgery **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Surgery **Outpatient (Same day)**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Surgery **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Surgery **Assistant Surgeon** **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Surgery **Assistant Surgeon** **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Surgery **Cosmetic/Reconstructive** **Must be Illness or Injury related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Surgery **Second Surgical Opinion** **Based on services rendered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Emergency and Urgent Care	Network Provider	Non-Network Provider
Emergency Services	You Must Pay: Copayment Applies Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Copayment Applies Network Deductible Applies Coinsurance Applies after Deductible 20% RBP After Annual Max $0
Urgent Care	You Must Pay: Copayment Applies Deductible Applies Coinsurance Applies after Deductible 20% RBP After Annual Max $0	You Must Pay: Copayment Applies Network Deductible Applies Coinsurance Applies after Deductible 20% RBP After Annual Max $0

Mental/Behavioral Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Mental/Behavioral Health/Substance Abuse **Outpatient Treatment Programs**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Mental/Behavioral Health/Substance Abuse/ Outpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Mental/Behavioral Health/Substance Abuse Inpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Mental/Behavioral Health/Substance Abuse Office Visit **Copayment applies to the first two Network Primary Care Physician visits, then Coinsurance and Deductible apply**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Other Services	Network Provider	Non-Network Provider
Abortion **Therapeutic-necessary to save the mother's life**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Ambulance	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Network Deductible Applies Coinsurance Applies after Deductible 20% RBP
Breast Prosthesis/Bra **Replacement prosthesis are covered if medically necessary 1 every 24 mos. Replacement bras are covered up to 6 per calendar year**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Other Services	Network Provider	Non-Network Provider
Gene and Cell Therapy Services **Prior Authorization Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Genetic Counseling **Prior Authorization Required** **Benefit level dependent upon where services rendered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Genetic Testing **Prior Authorization Required** **Benefit level dependent upon where services rendered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Infusion Therapy (Plan Approval Required)	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Other Services	Network Provider	Non-Network Provider
Durable Medical Equipment Wigs are covered. **Prior Authorization required for equipment over $2,500.**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Home Health Care **Plan Approval Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Other Services	Network Provider	Non-Network Provider
Hospice Care **Plan Approval Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Pain Management	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Private Duty Nursing **Plan Approval Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Skilled Nursing **Plan Approval Required** **Up to 100 days per Benefit Period**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Educational Training	Network Provider	Non-Network Provider
Diabetic Education **Outpatient/Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Diabetic Education **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Educational Training **Outpatient/Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Educational Training **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Educational Training	Network Provider	Non-Network Provider
Nutritional Counseling **Outpatient/Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Nutritional Counseling Inpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP

Preventive Care	Network Provider	Non-Network Provider
Smoking Cessation **Excludes hypnosis**	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP
Sterilization-Women **Reversals are not a covered expense** **Male Sterilization refer to Surgery benefit**	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP
Gynecological Pap Test	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP

Preventive Care	Network Provider	Non-Network Provider
Mammography **Routine Screening**	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP
Well Child Care	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP
Women's Birth Control **(Surgery includes all related services)**	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP

Preventive Care	Network Provider	Non-Network Provider
Breast Reconstructive Surgery after Mastectomy	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP
Colonoscopy **Outpatient/Office**	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP
Gynecological Exam	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP
Immunizations Beyond Well Child Care	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP

Preventive Care	Network Provider	Non-Network Provider
Physical **(Routine)** **1 exam Per Calendar Year**	Benefit not subject to cost sharing if provided as a routine preventive care screening.	You Must Pay: Coinsurance Applies 0% RBP

Affiliate Providers	Network Provider	Non-Network Provider
Chiropractic/Manipulation Therapy Coverage **Based on services rendered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Podiatry Coverage Office Visit **Based on services rendered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP
Massotherapy **Covered if services rendered by a Physical Therapist or Physician**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 50% RBP