

Health Care Benefit Chart

Issued & Underwritten by
AultCare Insurance Company

**STATE TEACHERS RETIREMENT SYSTEM OF OHIO
NON-MEDICARE
950010
JANUARY 1, 2022**



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 CHART-TABLE OF CONTENTS

II. BENEFIT LEVELS UNDER THE GROUP POLICY BETWEEN YOUR RETIREMENT SYSTEM AND AULTCARE INSURANCE COMPANY.....	B
COPAYMENT:.....	B
ANNUAL DEDUCTIBLE:.....	B
COINSURANCE (OUT-OF-POCKET EXPENSE):.....	B
ANNUAL OUT-OF-POCKET MAXIMUM.....	B
III. COVERED BENEFITS (SERVICES) UNDER YOUR 'S GROUP POLICY.....	D
ALLERGY EXTRACT	D
ALLERGY INJECTIONS.....	D
ALLERGY TESTING	D
ANESTHESIA.....	D
BIOFEEDBACK	E
CARDIAC REHABILITATION	F
CHEMO/RADIATION THERAPY	F
DIALYSIS	G
INFERTILITY TESTING	H
INFERTILITY TREATMENT.....	I
INJECTIONS (MEDICAL).....	I
INPATIENT HOSPITAL ADMISSION	J
INPATIENT HOSPITAL.....	J
PHYSICIAN.....	J
LABORATORY/X-RAY/DIAGNOSTIC	K
MAMMOGRAPHY	K
(MEDICAL DIAGNOSIS)	K
MATERNITY	L
OCCUPATIONAL THERAPY	M
OFFICE VISIT	N
TELEHEALTH	N
ORGAN DONOR COVERAGE	O
ORGAN TRANSPLANT COVERAGE	O
PHYSICAL THERAPY/REHABILITATION	P
PRE-ADMISSION TESTING	Q
PRESCRIPTION DRUGS.....	Q
ADMINISTERED IN OFFICE	Q
RESPIRATORY THERAPY	R
SPEECH THERAPY	S
SURGERY.....	T
ASSISTANT SURGEON	U
COSMETIC/RECONSTRUCTIVE.....	U
SECOND SURGICAL OPINION.....	U
EMERGENCY SERVICES.....	V
URGENT CARE.....	V
MENTAL HEALTH.....	W
ALCOHOL/SUBSTANCE ABUSE	X
OUTPATIENT.....	X
BREAST PROSTHESIS/BRA.....	Z
DURABLE MEDICAL EQUIPMENT.....	Z

GENE AND CELL THERAPY SERVICES	Z
GENETIC COUNSELING.....	AA
INFUSION THERAPY.....	AA
HOME HEALTH CARE.....	BB
HOSPICE CARE	BB
PAIN MANAGEMENT.....	CC
PRIVATE DUTY NURSING.....	CC
SKILLED NURSING	CC
SMOKING CESSATION.....	DD
STERILIZATION-WOMEN	DD
DIABETIC EDUCATION.....	EE
EDUCATIONAL TRAINING	EE
NUTRITIONAL COUNSELING.....	FF
GYNECOLOGICAL PAP TEST.....	GG
MAMMOGRAPHY	GG
(ROUTINE SCREENING).....	GG
WELL CHILD CARE	HH
WOMEN'S BIRTH CONTROL.....	HH
BREAST RECONSTRUCTIVE SURGERY AFTER MASTECTOMY	II
COLONOSCOPY	II
GYNECOLOGICAL EXAM	II
IMMUNIZATIONS BEYOND WELL CHILD CARE	II
PHYSICAL	JJ
(ROUTINE).....	JJ
CHIROPRACTIC/MANIPULATION THERAPY	KK
MASSOTHERAPY	KK
PODIATRY COVERAGE.....	LL

Benefits Chart

Plan: STRS NON-MEDICARE

Plan Year: 2022

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 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.

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

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 if You go to a Non-Network Provider.

Policy Provision	Network Provider	Non-Network Provider
<p>Copayment: The set dollar amount You pay out-of-pocket for each Doctor Office Visit. The Copayment does not count against Your Annual Deductible. Application of Copayment is dependent upon services rendered.</p>	<p>\$20 Primary Care Physician \$20 Telehealth \$150 ER \$40 Urgent Care</p>	<p>\$150 ER \$40 Urgent Care</p>
<p>Annual Deductible: The minimum amount You must pay out-of-pocket each year before Benefits are paid under the Policy. Your Plan has a Non-Integrated Deductible.</p>	<p>\$2,500 for an individual</p>	<p>\$5,000 for an individual</p>
<p>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.</p>	<p>Your share of the charge 20%</p>	<p>Your share of the charge 50% plus any charges in excess of RBP</p>
<p>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 include Copayments. Your Plan has a Non-Integrated Out-of-Pocket.</p>	<p>\$6,500 per individual</p>	<p>\$13,000 per individual</p>

Note: 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: Network and Non-Network Deductibles do not accumulate towards each other.

Ohio's House Bill 388 and the Federal "No Surprises Act establish patient protections including from Out-of-Network providers' surprise bills ("balance billing") for emergency care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.

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

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

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

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

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Chemo/Radiation Therapy</p> <p>Outpatient</p> <p>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</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Chemo/Radiation Therapy</p> <p>Inpatient</p> <p>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</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Dialysis</p> <p>In Office</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Dialysis</p> <p>Outpatient</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

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

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

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

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

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Mammography (Medical Diagnosis) Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Mammography (Medical Diagnosis) Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Maternity	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP

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

<p>Occupational Therapy</p> <p>Inpatient</p> <p>Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Office Visit</p> <p>Illness</p> <p>Copayment applies to the first two Network Primary Care Physician visits, then Coinsurance and Deductible apply</p>	<p><u>You Must Pay:</u> Copayment Applies</p> <p>Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Telehealth</p> <p>Based on services rendered</p>	<p><u>You Must Pay:</u> Copayment Applies</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Office Visit</p> <p>Injury</p> <p>Copayment applies to the first two Network Primary Care Physician visits, then Coinsurance and Deductible apply</p>	<p><u>You Must Pay:</u> Copayment Applies</p> <p>Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Organ Donor Coverage</p> <p>Coordinate with Donor's coverage unless donor expenses covered in global fee</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Organ Transplant Coverage</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Physical Therapy/Rehabilitation</p> <p>In Office Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Physical Therapy/Rehabilitation</p> <p>Outpatient Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Physical Therapy/Rehabilitation</p> <p>Inpatient Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

<p>Pre-Admission Testing</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Prescription Drugs Administered in Office</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

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

<p>Speech Therapy In Office</p> <p>Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Speech Therapy Inpatient</p> <p>Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Speech Therapy Outpatient</p> <p>Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

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

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

Emergency and Urgent Care	Network Provider	Non-Network Provider
Emergency Services	<u>You Must Pay:</u> Copayment Applies After Annual Max \$0	<u>You Must Pay:</u> Copayment Applies RBP

Urgent Care	<u>You Must Pay:</u> Copayment Applies After Annual Max \$0	<u>You Must Pay:</u> Copayment Applies RBP
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Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Mental Health Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Mental Health Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Mental Health Outpatient Treatment Programs	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP

Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Alcohol/Substance Abuse Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Alcohol/Substance Abuse Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Alcohol/Substance Abuse Outpatient Treatment Programs	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP

Other Services	Network Provider	Non-Network Provider
<p>Abortion Therapeutic-necessary to save the mother's life</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Ambulance</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Network Deductible Applies</p> <p>Coinsurance Applies after Deductible 20% RBP</p>

Other Services	Network Provider	Non-Network Provider
<p>Breast Prosthesis/Bra</p> <p>Replacement prosthesis are covered if medically necessary 1 every 24 months. Replacement bras are covered up to 6 per calendar year</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Durable Medical Equipment</p> <p>Wigs are covered</p> <p>Prior Authorization needed for equipment that exceeds \$2,500</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Gene and Cell Therapy Services</p> <p>Prior Authorization Required</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

<p>Genetic Counseling (Plan Approval Required)</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Infusion Therapy (Plan Approval Required)</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

Other Services	Network Provider	Non-Network Provider
<p>Home Health Care (Plan Approval Required)</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
<p>Hospice Care (Plan Approval Required)</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>

Other Services	Network Provider	Non-Network Provider
Pain Management	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Private Duty Nursing (Plan Approval Required)	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Skilled Nursing (Plan Approval Required) Up to 100 days per Benefit Period	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP

Other Services	Network Provider	Non-Network Provider
<p>Smoking Cessation</p>	<p>Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.</p>	<p><u>You Must Pay:</u> Coinsurance Applies 0% RBP</p>
<p>Sterilization-Women</p> <p>Reversals are not a covered expense</p> <p>Male Sterilization refer to Surgery benefit</p>	<p>Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.</p>	<p><u>You Must Pay:</u> Coinsurance Applies 0% RBP</p>

Educational Training	Network Provider	Non-Network Provider
Diabetic Education Outpatient	Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Diabetic Education Inpatient	Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Educational Training Outpatient	Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Educational Training Inpatient	Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP

Educational Training	Network Provider	Non-Network Provider
Nutritional Counseling Outpatient	Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Nutritional Counseling Inpatient	Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP

Preventive Care	Network Provider	Non-Network Provider
<p>Gynecological Pap Test</p>	<p>Benefit not subject to cost sharing if provided as a routine preventive care screening.</p>	<p><u>You Must Pay:</u> Coinsurance Applies 0% RBP</p>
<p>Mammography (Routine Screening)</p> <p>Network providers may not balance bill.</p> <p>Non-Network providers may only bill for appropriate Cost Share, which includes Deductible and Coinsurance only. They may not balance bill for any charges over RBP</p>	<p>Benefit not subject to cost sharing if provided as a routine preventive care screening.</p>	<p><u>You Must Pay:</u> Coinsurance Applies 0% RBP</p>

Preventive Care	Network Provider	Non-Network Provider
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)	Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.	You Must Pay: Coinsurance Applies 0% RBP

Preventive Care	Network Provider	Non-Network Provider
Breast Reconstructive Surgery after Mastectomy	<p>You Must Pay: Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p>You Must Pay: Deductible Applies</p> <p>Coinsurance Applies after Deductible 50% RBP</p>
Colonoscopy	<p>Benefit not subject to cost sharing if provided as a routine preventive care screening.</p>	<p>You Must Pay: Coinsurance Applies 0%RBP</p>
Gynecological Exam	<p>Benefit not subject to cost sharing if provided as a routine preventive care screening.</p>	<p>You Must Pay: Coinsurance Applies 0%RBP</p>
Immunizations Beyond Well Child Care	<p>Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.</p>	<p>You Must Pay: Coinsurance Applies 0%RBP</p>

Preventive Care	Network Provider	Non-Network Provider
Physical (Routine)	Benefit not subject to cost sharing if provided as a routine preventive care screening.	<u>You Must Pay:</u> Coinsurance Applies 0% RBP
Preventive Care	Network Provider	Non-Network Provider
Ultrasound (Routine Maternity)	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP

Affiliate Providers	Network Provider	Non-Network Provider
Chiropractic/Manipulation Therapy Coverage Office Visit	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Chiropractic Coverage Other Services	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Chiropractic Coverage Diagnostic Testing	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Massotherapy (Plan Approval Required) Covered if services rendered by a MD or Physical Therapist for treatment of injury or illness	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP

Affiliate Providers	Network Provider	Non-Network Provider
Podiatry Coverage Office Visit	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Podiatry Coverage Diagnostic/Testing	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Podiatry Coverage Surgery	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP
Podiatry Coverage Other Services	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP