

Health Care Benefit Chart

Issued & Underwritten by

AultCare Insurance Company

STATE TEACHERS RETIREMENT SYSTEM OF OHIO

NON-MEDICARE

950010

JANUARY 1, 2023



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.

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Benefits Chart

Plan: STRS NON-MEDICARE

Plan Year: 2023

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 Primary Care Physician \$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.</p> <p>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 include Your Deductible.</p> <p>Your Plan has a Non-Integrated Out-of-Pocket.</p>	<p>\$6,500 per individual</p>	<p>\$13,000 per individual</p>
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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 Revised Code Sections 3902.50 through 3902.54, Ohio Administrative Code Section 3901-8-17 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.

AultCare will determine whether the Covered Services can be provided by a Network Provider, and that determination will be final and conclusive, subject to any available appeals process. If You do not receive written approval in advance of receiving Covered Services from a Non-Network Provider, services will be covered at the Non-Network provider level and You will be subject to balance billing and increased Out-of-Pocket expenses. Services provided to You in an Emergency Medical Condition will be covered at the Network level of benefit.

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
<p>Dialysis</p> <p>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>
<p>Infertility Testing</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>Infertility Testing</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>
<p>Infertility Testing</p> <p>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
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
<p>Injections (Medical)</p> <p>Outpatient</p> <p>Not including routine Immunizations</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>Injections (Medical)</p> <p>Inpatient</p> <p>Not including routine Immunizations</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>Inpatient Hospital Admission</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>Inpatient Hospital Physician</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
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
<p>Mammography (Medical Diagnosis)</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>
<p>Mammography (Medical Diagnosis)</p> <p>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>
<p>Maternity</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>Autism Spectrum Disorder</p> <p>Benefits based on services rendered</p> <p>20 visits for each service per year for Physical Rehabilitation Services, Speech & Language and/or Occupational Therapy performed by licensed therapists</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 and Therapeutic therapies supported by empirical evidence, which includes, but not limited to Applied Behavioral Analysis provided by or under the supervision of a professional who is licensed, certified or registered by an appropriate agency of the state to perform the services in accordance to the treatment plan, 20 hours per week.</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><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>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>
<p>Physical Therapy/Rehabilitation</p> <p>Outpatient Illness or Injury Related</p>	<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>
<p>Physical Therapy/Rehabilitation</p> <p>Inpatient Illness or Injury Related</p>	<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>
<p>Pre-Admission Testing</p>	<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>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Prescription Drugs Administered 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 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 Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP</p>
<p>Speech Therapy Outpatient Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 50% RBP</p>
<p>Speech Therapy Inpatient Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies 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
<p>Emergency Services</p> <p>*Federal No Surprises Act - Surprise Billing protections may apply.</p>	<p><u>You Must Pay:</u> Deductible & Coinsurance Applies 20%</p> <p>Copayment Applies after Deductible</p> <p>After Out of Pocket Max \$0</p>	<p><u>You Must Pay:</u> Network Deductible & Coinsurance Applies 20% RBP</p> <p>Copayment Applies after Deductible</p>
<p>Urgent Care</p>	<p><u>You Must Pay:</u> Deductible & Coinsurance Applies 20%</p> <p>Copayment Applies after Deductible</p> <p>After Out of Pocket Max \$0</p>	<p><u>You Must Pay:</u> Network Deductible & Coinsurance Applies 20% RBP</p> <p>Copayment Applies after Deductible</p>

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
Ambulance	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Network Deductible Applies Coinsurance Applies after Deductible 20% RBP
Attention Deficit Disorder	<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>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</p> <p>(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>
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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>You Must Pay: 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>You Must Pay: Coinsurance Applies 0% RBP</p>

Preventive Care	Network Provider	Non-Network Provider
Well Child Care	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
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	<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
Colonoscopy Outpatient/Office	Benefit not subject to cost sharing if provided as a routine preventive care screening.	<u>You Must Pay:</u> Coinsurance Applies 0% RBP
Gynecological Exam	Benefit not subject to cost sharing if provided as a routine preventive care screening.	<u>You Must Pay:</u> Coinsurance Applies 0% RBP
Immunizations Beyond Well Child Care	Benefits are not subject to cost sharing when included in the list of ACA mandated preventive care services.	<u>You Must Pay:</u> Coinsurance Applies 0% RBP

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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
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
<p>Chiropractic/Manipulation Therapy Coverage</p> <p>Office Visit</p>	<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>
<p>Chiropractic Coverage</p> <p>Other Services</p>	<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>
<p>Chiropractic Coverage</p> <p>Diagnostic Testing</p>	<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>
<p>Massotherapy (Plan Approval Required)</p> <p>Covered if services rendered by a MD or Physical Therapist for treatment of injury or illness</p>	<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>