---SILVER--- SCHEDULE OF MEDICAL BENEFITS

Maximum Annual Benefit for Medical Care Unlimited

		Comments
Plan Year Deductible: Per Covered Person Per Family	 $0 $0	
Plan Year Out-of-Pocket Maximum: Per Covered Person Per Family	 $7,000 $14,000	Includes medical and prescription drugs eligible expenses.
The charges for the following do not accrue to the Out-of-Pocket Maximum: • Cost Containment Penalties • Expenses incurred for Non-Covered Services		

Benefits and Services	Plan Pays *Allowed Amount	Comments
The Plan does not cover out-of-network services except as required under the provisions of this document.		
HOSPITAL BENEFITS		
Inpatient Hospital Services	$1,000 Co-pay per Admission, then 100% *Limited to seven (7) days per plan year combined with inpatient mental health and inpatient substance abuse.*	*Pre-notification required.* Benefit based on Semi-private room rate. Refer to "Maternity Inpatient Hospital" for additional benefit information.
Maternity Services *Includes, but is not limited to facility, professional and physician fees for uncomplicated maternity related care.*	$2,300 Co-pay, then 100%	*Pre-notification required.* This applies only to maternity expenses. Genetic testing at birth is limited to a $500 benefit per pregnancy.
Emergency Room	$500 Co-pay, then 100% *Limited to one (1) visit per plan year*	Co-pay is waived if admitted.
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS		
Inpatient Mental Health Treatment	$1,000 Co-pay per Admission, then 100% *Limited to seven (7) days per plan year combined with inpatient hospitalization and inpatient substance abuse.*	*Pre-notification required.*
Mental Health Treatment *(Office Setting)*	$50 Co-pay, then 100% *Limited to six (6) visits per plan year combined with substance abuse and specialist office visits.*	This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. *(this will accrue toward the applicable visit limit)*

Benefits and Services	Plan Pays *Allowed Amount	Comments
The Plan does not cover out-of-network services except as required under the provisions of this document.		
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS *(continued)*		
Inpatient Substance Abuse Treatment	$1,000 Co-pay per Admission, then 100% *Limited to seven (7) days per plan year combined with inpatient hospitalization and inpatient mental health.*	*Pre-notification required.*
Substance Abuse Treatment *(Office Setting)*	$50 Co-pay, then 100% *Limited to six (6) visits per plan year combined with mental health and specialist office visits.*	This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. *(this will accrue toward the applicable visit limit)*
MISCELLANEOUS SERVICES AND SUPPLIES BENEFITS		
Home Health Care	$50 Co-pay, then 100% *Limited to eight (8) visits per plan year*	
Ambulance Service	100%	Limited to one occurrence per plan year. Air ambulance is not covered.
Clinical Trials	Paid as any other benefit	Refer to *Clinical Trials* in the *Covered Medical Expense* section.
PROFESSIONAL SERVICES BENEFITS		
Surgical Services *Inpatient* *Outpatient* *Facility and professional fees* *Office*	$500 Co-pay, then 100% *Limited to two (2) procedures per plan year* $500 Co-pay, then 100% *Limited to two (2) procedures per plan year* $70 Co-pay, then 100% *Limited to two (2) procedures per plan year*	This co-payment is in addition to any other applicable place of service co-payment as shown in this schedule. *Pre-notification required for all In-patient and Outpatient surgical procedures.* Pre-notification not required for office surgery.
Physician's Office Visits *Includes family and general physician, internist and OB/GYN physician*	$35 Co-pay, then 100% *Limited to six (6) visits per plan year*	This benefit is for a billed office visit only. Other services rendered during an office visit will be considered as shown in this document. This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. *(this will accrue toward the applicable visit limit)*
Specialist's Office Visits	$50 Co-pay, then 100% *Limited to six (6) visits per plan year combined with mental health and substance abuse office visits.*	This benefit is for a billed office visit only. Other services rendered during an office visit will be considered as shown in this document. This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. *(this will accrue toward the applicable visit limit)*

Benefits and Services	Plan Pays *Allowed Amount	Comments
The Plan does not cover out-of-network services except as required under the provisions of this document.		
PROFESSIONAL SERVICES BENEFITS *(continued)*		
Urgent Care	$50 Co-pay, then 100% *Limited to three (3) visits per plan year*	
Diagnostic X-ray & Laboratory Expenses *Non-hospital based*	$50 Co-pay, then 100% *Limited to four (4) tests/procedures per plan year*	
Advanced Imaging	$500 Co-pay, then 100% *Limited to two (2) visits per plan year*	Includes MRI, MRA, CT / PET Scan and nuclear imaging.
REHABILITATION THERAPY BENFITS		
Physical Therapy Occupational Therapy	$50 Co-pay, then 100% *Limited to a combined six (6) visits per plan year*	
PREVENTIVE CARE BENEFITS		
Preventive Services *As established by section 2713 of the Affordable Care Act (ACA)*	100%	Refer to the *Covered Medical Expense* section under *Preventive* for additional information.
Well Child Care	100%	
Well Adult Care	100%	
Well Women Care	100%	Breast Pump reimbursement is limited to $125.
Mammogram	100%	Includes 3D mammograms.
GYN & Pap	100%	
PSA Testing	100%	
Colonoscopy	100%	
Well Care includes reimbursement for the following services: office visits, physical examination, laboratory tests, x-rays, immunizations and cancer screenings.		

- Allowed amount - The Plan will consider the allowed amount designated by the Preferred Provider Organization.
- UCR -The Plan will consider the Usual and Customary and Reasonable amount of the services based on the geographic location of the provider of service.

This schedule is not all inclusive. Refer to the Covered Medical Expenses and Medical Exclusions and Limitations sections for more information.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS ***(Available through a separate Pharmacy Benefit Manager)***			
Plan Year Deductible: Per Covered Person	$250		
	Retail Covered Person Pays *30-day supply* ***(After Deductible)***	**Mail-Order Covered Person Pays** *Up to 90-day supply* ***(After Deductible)***	Prescription drugs regardless of tier will be limited to a $500 per month benefit for any 30-day fill and $1,500 for a 90-day supply.
Generic* *(tier-1)*	30% *(Deductible Waived)*	30% *(Deductible Waived)*	
Preferred Brand *(tier-2)*	30%	30%	
Non-Preferred *(tier-3)*	30%	30%	
Specialty Medications *(tier-4)***	Not Covered	Not Covered	

*** The Plan will cover charges for any preventive care drugs as required by the ACA. The Plan may use reasonable medical management techniques to control costs and promote efficient delivery of care, such as covering a generic drug without cost sharing and imposing cost sharing for equivalent branded drugs.**

Your Doctor may prescribe a name brand drug that has a lower cost generic drug equivalent. If either drug is acceptable to your Doctor, you are encouraged to choose the generic drug from your pharmacist. However, if you choose the name brand drug, you must pay the difference in cost between the generic and name brand.

24