

| COVERED SERVICE | COPAYMENT |
|---|--|
| <p>PHYSICIAN OFFICE SERVICES</p> <p>Physician Office Services Include:</p> <ul style="list-style-type: none"> • Physician Office Visits • Medications, supplies and materials administered in the office • Second Surgical Opinion <p>Laboratory Tests and X-Ray performed in the Physician's office</p> <p>MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in the Physician's office</p> <p>Allergy Services</p> <ul style="list-style-type: none"> • Office Visits • Allergy Testing • Serum • Injection Administration <p>Surgical Procedures performed in the Physician's Office</p> | <p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>No Copay – After Deductible</p> <p>20% Copay – After Deductible</p> <p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>50% of the Allowable Amount – After Deductible 50% of the Allowable Amount – After Deductible 50% of the Allowable Amount – After Deductible</p> <p>20% Copay – After Deductible</p> |
| <p>PREVENTIVE SERVICES</p> <p>Preventive Services Include:</p> <ul style="list-style-type: none"> • Annual Routine Physicals • Well Baby and Well Child Care • Routine Eye, Speech and Hearing Screenings for Children when performed during an office visit • Routine Immunizations for ages 6 and older • Examinations and Testing for the detection of Prostate Cancer • Routine Laboratory and X-Ray <p>Immunizations for Newborns (birth to 6-years of age)</p> <p>Newborn Child Hearing Screenings (birth to 30-days old)</p> <p>Well Woman Exam including Routine Annual Physicals including low dose mammography screening.</p> <p>Preventive Diagnostics and Testing:</p> <ul style="list-style-type: none"> • Non-routine screening mammograms including Digital, X-ray and Ultrasound • Screening for the detection of Colorectal Cancer <i>(If other procedures are needed during the screening, additional Copayments, Deductible, and/or Coinsurance will apply.)</i> • Bone Mass Measurement | <p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>No Copay – Deductible Waived</p> <p>No Copay – Deductible Waived</p> <p>\$30 per office visit – Deductible Waived</p> <p>20% Copay – After Deductible</p> |

| COVERED SERVICE | COPAYMENT |
|--|--|
| <p>FAMILY PLANNING SERVICES Family Planning and Counseling</p> <p>Contraceptive Devices, Implants and Injections including:</p> <ul style="list-style-type: none"> • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo-Provera™ Injections <p><u>STERILIZATION PROCEDURES</u> (Vasectomy & Tubal Ligation)</p> <ul style="list-style-type: none"> • When performed in an Outpatient Facility • When performed in the Physician's Office • When performed in an Inpatient Facility | <p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>50% of the Allowable Amount for all charges – After Deductible. Applies to materials, procedures, and services.</p> <p>20% Copay – After Deductible 20% Copay – After Deductible See Inpatient Services</p> |
| <p>DIABETIC SERVICES Diabetic Self-Management Education</p> <p>Insulin and Diabetic Insulin</p> <ul style="list-style-type: none"> • 30 Day Supply <ul style="list-style-type: none"> ○ 1st tier - Generic Drugs ○ 2nd tier - Brand name drugs on drug list ○ 3rd tier - Brand name drugs not on drug list • Mail Order (up to 90- day supply) <ul style="list-style-type: none"> ○ 1st tier - Generic Drugs ○ 2nd tier - Brand name drugs on drug list ○ 3rd tier - Brand name drugs not on drug list <p>Test Strips</p> <ul style="list-style-type: none"> • Level 1 Strips • Level 2 Strips <p>Other Diabetic Supplies and Equipment (30 Day Supply)</p> | <p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>\$20 per prescription – After Deductible \$50 per prescription – After Deductible \$100 per prescription – After Deductible</p> <p>\$60 per prescription – After Deductible \$150 per prescription – After Deductible \$300 per prescription – After Deductible</p> <p>10% per item – After Deductible 20% per item – After Deductible</p> <p>20% per item – After Deductible</p> |
| <p>SPECIALTY SERVICES/PHARMACY Specialty Services/Pharmacy Include:</p> <ul style="list-style-type: none"> • Medical Injectable Drugs (excluding Depo-Provera™ injectables) • Defined Hybrid Injectables • Radiation Therapy • Transplant Anti-rejection Therapy • Home Infusion Medications (excluding “self-injectable” drugs) • Specified Cancer Chemotherapy • Defined Associated Agents | <ul style="list-style-type: none"> • When covered service cost is \$500 or less: <i>See physician office services, outpatient services/surgery, or inpatient services for applicable copayments.</i> • When covered service cost is more than \$500: <i>30% Copay – After Deductible, not to exceed \$3,000 Out-of-Pocket Maximum for these specific services. See Section 10, Definitions in Your Evidence of Coverage</i> |

| COVERED SERVICE | COPAYMENT |
|---|--|
| <p>EMERGENCY ROOM SERVICES</p> <p>Emergency Room</p> <p>Minor Emergency/Urgent Care Center</p> <p>Ambulance</p> | <p>20% Copay – After Deductible Emergency Room Copay is waived if admitted to Hospital</p> <p>20% Copay – After Deductible</p> <p>20% Copay – After Deductible</p> |
| <p>OTHER HEALTH CARE SERVICES</p> <p>Limited Accidental Dental Care and Medically Related Oral Surgeries: <i>Limited to \$1,000 Calendar Year Maximum Benefit</i></p> <p>Therapy Services: <i>Limited to 20 visits per Therapy Service per Calendar Year</i></p> <ul style="list-style-type: none"> • Rehabilitation Therapy • Speech Therapy • Occupational Therapy • Physical Therapy <p>Hospice Care: <i>Lifetime Maximum of \$10,000</i></p> <p>Spinal Manipulation: <i>Limited to 10 visits per Calendar Year</i></p> <p>Pain Management Services</p> <p>Durable Medical Equipment (DME): <i>DME is limited to \$2,000 per Calendar Year. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the \$2,000 maximum.</i></p> <p>Medical Supplies</p> <p>Prosthetics: External Devices: <i>Lifetime Maximum of \$4,000 per Device/Limb</i></p> <p>Orthotics</p> <p>Internal Implantable Devices</p> <p>Dialysis Services (Inpatient & Outpatient)</p> | <p>20% Copay – After Deductible</p> <p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>20% Copay – After Deductible</p> <p>\$50 per visit – Deductible Waived</p> <p>Included in the physician office services, outpatient services/surgery, or inpatient services copayment.</p> <p>50% of the Allowable Amount per piece of equipment or supply – After Deductible</p> <p>50% of the Allowable Amount per piece of equipment or supply – After Deductible</p> <p>50% of the Allowable Amount per device – After Deductible</p> <p>50% of the Allowable Amount per device – After Deductible</p> <p>50% of the Allowable Amount per device – After Deductible</p> <p>Included in the physician office services, outpatient services/surgery, or inpatient services copayment.</p> |

| COVERED SERVICE | COPAYMENT |
|--|---|
| <p>Organ Transplant Services (Inpatient & Outpatient) <i>Lifetime Maximum of \$300,000</i></p> <p>Home Health Services: <i>Limited to 20 visits per Covered Service per Calendar Year</i></p> <ul style="list-style-type: none"> • Includes treatment of covered illness or injury in your home • EXCLUDES speech, physical, and occupational therapy | <p>Included in the physician office services, outpatient services/surgery, or inpatient services copayment.</p> <p>20% Copay – After Deductible</p> |

NOTE: This benefit plan does not include maternity coverage.