## SCHEDULE PPO A

### PPO A SCHEDULE OF BENEFITS

### CASEBP

| **COST-SHARING** | **Participating Member Responsibility for Cost-Sharing** | **Non-Participating Member Responsibility for Cost-Sharing** | **LIMITS** |
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| **Deductible**<br>• Individual<br>• Family | | $250<br>$750 | |
| **Out-of-Pocket Limit**<br>• Individual<br>• Family | $1,000<br>$3,000 | $1,100<br>$3,300 | |
| | | **See Section IV of the Certificate for a description of how We calculate the Allowed Amount. Any charges of Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible or Out-Of-Pocket Limit. You must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount** | |
| **OFFICE VISITS**<br>Primary Care Physicians and Specialists | **Participating Member Responsibility for Cost-Sharing** | **Non-Participating Member Responsibility for Cost-Sharing** | **Limits** |
| Office Visits (or Home Visits) | $10 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |
| **PREVENTIVE CARE** | **Participating Member Responsibility for Cost-Sharing** | **Non-Participating Member Responsibility for Cost-Sharing** | **Limits** |

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| • Well Child Visits and Immunizations* | Covered in full | Covered in full | See Benefit For Description |
| • Adult Annual Physical Examinations* | Covered in full | 20% Coinsurance after Deductible | |
| • Adult Immunizations* | Covered in full | 20% Coinsurance after Deductible | |
| • Routine Gynecological /Well Woman Exams* | Covered in full | 20% Coinsurance after Deductible | |
| • Mammography Screenings* | Covered in full | 20% Coinsurance after Deductible | |
| • Sterilization Procedures for Women* | Covered in full | 20% Coinsurance after Deductible | |
| • Vasectomy | $10 Copayment | 20% Coinsurance after Deductible | |
| • Bone Density Testing* | Covered in Full | 20% Coinsurance after Deductible | |
| • Screening for Prostate Cancer | Covered in full | 20% Coinsurance after Deductible | |
| • All other preventative services required by USPSTF AND HRSA.<br>*When preventative services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. | Covered in Full<br>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing) | 20% Coinsurance after Deductible<br>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing) | |
| **EMERGENCY CARE** | **Participating Member** | **Non-Participating Member** | **Limits** |

| | **Responsibility for Cost-Sharing** | **Responsibility for Cost-Sharing** | |
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| Pre-Hospital Emergency Medical Services (Ambulance Services) | $50 Copayment | $50 Copayment | See Benefit For Description |
| Non-Emergency Ambulance Services<br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |
| Emergency Department<br><br>Copayment waived if Hospital admission. | $50 Copayment | $50 Copayment | See Benefit For Description |
| Urgent Care Center | $25 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |
| **PROFESSIONAL SERVICES AND OUTPATIENT CARE** | **Participating Member Responsibility for Cost-Sharing** | **Non-Participating Member Responsibility for Cost-Sharing** | **Limits** |
| Advanced Imaging Services<br>• Performed in a Freestanding Radiology Facility or Office Setting<br><br>• Performed as Outpatient Hospital Services | $10 Copayment<br><br>Covered in Full | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | See Benefit For Description |
| Allergy Testing & Treatment | Covered in Full | 20% Coinsurance after Deductible | See Benefit For Description |
| Ambulatory Surgical Center Facility Fee | $10 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |
| Anesthesia Services (all settings) | Covered in full | 20% Coinsurance after Deductible | See Benefit For Description |
| Autologous Blood Banking<br><br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after Deductible | See Benefits For Description |
| Cardiac & Pulmonary Rehabilitation<br>• Performed in a Specialist Office<br><br>• Outpatient Hospital Services | $10 Copayment<br><br>$10 Copayment | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | See Benefits For Description |

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| • Inpatient Hospital Services | Covered in Full | 20% Coinsurance after deductible | |
| Chemotherapy<br>• Performed in an Office<br><br>• Performed as Outpatient Hospital Services<br><br>**Preauthorization Required** | Covered in Full<br><br>Covered in Full | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | See Benefit For Description |
| Chiropractic Services | $10 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |
| Diagnostic Testing<br>• Performed in an Office<br><br>• Performed as Outpatient Hospital Services | Covered in Full<br><br>Covered in Full | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | See Benefit For Description |
| Dialysis<br>• Performed in an Office<br><br>• Performed in a Freestanding Center or Specialist Office Setting<br><br>• Performed as Outpatient Hospital Services | Covered in Full<br><br>Covered in Full<br><br>Covered in Full | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | See Benefit For Description |
| Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)<br><br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after Deductible | 60 visits per condition combined therapies per Plan Year |
| Home Health Care<br><br>**Preauthorization Required** | Covered in Full | 20% Coinsurance after $50 Deductible | 40 Visits per Plan Year |

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| Infertility Services<br><br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after deductible | See Benefit For Description |
| Infusion Therapy<br>• Performed in an Office<br><br>• Performed as Outpatient Hospital Services<br><br>• Home Infusion Therapy | Covered in Full<br><br>Covered in Full<br><br>Covered in Full | 20% Coinsurance after Deductible<br><br>20% Coinsurance after deductible<br><br>20% Coinsurance after Deductible | See Benefit For Description<br><br>Home Infusion counts towards 40 Home Health Care Visit Limits per Plan Year |
| Inpatient Medical Visits | $10 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |
| Laboratory Procedures<br>• Performed in an Office<br><br>• Performed Freestanding Laboratory Facility<br><br>• Performed as Outpatient Hospital Services | Covered in Full<br><br>Covered in Full<br><br>Covered in Full | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | See Benefit For Description |
| Maternity & Newborn Care<br><br>• Prenatal Care<br><br>• Inpatient Hospital Services<br><br>• Physician and Nurse Midwife Services for Delivery<br><br>• Breast Pump<br><br>**Preauthorization Required for Inpatient Services** | Covered In Full<br><br>Covered in Full<br><br>$10 Copayment<br><br>Covered in Full | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | See Benefit For Description<br><br>Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early<br><br>Covered for duration of breast feeding |
| Outpatient Hospital Surgery Facility Charge | $10 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |

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| Preadmission Testing | Covered in Full | 20% Coinsurance after Deductible | See Benefit For Description |
| Diagnostic Radiology Services<br>• Performed in an Office<br>• Performed in a Freestanding Radiology Facility<br>• Performed as Outpatient Hospital Services | $10 Copayment<br>$10 Copayment<br>Covered in Full | 20% Coinsurance after Deductible<br>20% Coinsurance after Deductible<br>20% Coinsurance After Deductible | See Benefit For Description |
| Therapeutic Radiology Services<br>• In a Freestanding Radiology Facility/Office<br>• Performed as Outpatient Hospital Services<br>**Preauthorization Required** | $10 Copayment<br>Covered in Full | 20% Coinsurance after Deductible<br>20% Coinsurance after Deductible | See Benefit For Description |
| Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)<br>Preauthorization Required | $10 Copayment | 20% Coinsurance after Deductible | 60 visits per condition, per lifetime combined therapies. Speech and Physical Therapy are only Covered following a Hospital stay or surgery. |
| Second Opinions on the Diagnosis of Cancer, Surgery & Other<br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after Deductible<br>Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist | See Benefit For Description |
| Surgical Services (Including Oral Surgery; Reconstructive | | | See Benefit For Description |

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| Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)<br>• Inpatient Hospital Surgery<br>• Outpatient Hospital Surgery<br>• Surgery Performed at an Ambulatory Surgical Center<br>• Office Surgery<br><br>**Preauthorization; Required** | Covered in Full<br>$10 Copayment<br>$10 Copayment<br>$10 Copayment | 20% Coinsurance after Deductible<br>20% Coinsurance after Deductible<br>20% Coinsurance after Deductible<br>20% Coinsurance after Deductible | All Transplants Must be Performed at Designated Facilities. |
| **ADDITIONAL SERVICES, EQUIPMENT & DEVICES** | **Participating Member Responsibility for Cost-Sharing** | **Non-Participating Member Responsibility for Cost-Sharing** | **Limits** |
| **ABA Treatment for Autism Spectrum Disorder**<br><br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after Deductible | 680 Hours Per Plan Year |
| **Assistive Communication Devices for Autism Spectrum Disorder**<br><br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |
| Diabetic Equipment, Supplies & Self-Management Education<br>• Diabetic Equipment, Supplies<br>• Insulin (30-Day Supply)<br>• Diabetic Education<br><br>**Preauthorization Required** | $10 Copayment<br>See the Prescription Drug Cost-Sharing<br>$10 Copayment | 20% Coinsurance after Deductible<br>20% Coinsurance after Deductible<br>20% Coinsurance after Deductible | See Benefit For Description<br>See Prescription Drug Benefit |
| Durable Medical Equipment & Braces | 20% Coinsurance not subject to Deductible | 20% Coinsurance after Deductible | See Benefit For Description |

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| **Preauthorization Required** | | | |
| Cochlear Implants<br><br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after Deductible | One Per Ear Per Time Covered |
| Hospice Care<br>• Inpatient<br><br>• Outpatient<br><br>**Preauthorization Required** | Covered in Full<br><br>Covered in Full | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | 210 Days per Plan Year<br><br>5 Visits for Family Bereavement Counseling |
| Medical Supplies | 20% Coinsurance not subject to Deductible | 20% Coinsurance after Deductible | See Benefit For Description |
| Prosthetic Devices<br>• External<br><br>• Internal<br><br>• **Preauthorization Required for Prosthetics over $1,000** | 20% Coinsurance not subject to Deductible<br><br>20% Coinsurance not subject to Deductible | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | One Prosthetic Device, per limb, per lifetime. |
| **INPATIENT SERVICES & FACILITIES** | **Participating Member Responsibility for Cost-Sharing** | **Non-Participating Member Responsibility for Cost-Sharing** | **Limits** |
| Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)<br><br>**Preauthorization Required** | Covered in Full | 20% Coinsurance after Deductible | See Benefit For Description |
| Observation Stay<br><br>**Preauthorization Required** | Covered in Full | 20% Coinsurance after Deductible | See Benefit For Description |
| Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)<br><br>**Preauthorization Required** | Covered in Full 45 Days SNF Only | No Coverage | 45 Days Only |
| Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)<br><br>**Preauthorization Required** | Covered in Full | 20% Coinsurance after Deductible | 60 Consecutive Days per Condition per Lifetime |
| **MENTAL HEALTH &** | **Participating** | **Non-Participating** | **Limits** |

| **SUBSTANCE USE DISORDER SERVICES** | **Member Responsibility for Cost-Sharing** | **Member Responsibility for Cost-Sharing** | |
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| Inpatient Mental Health Care (for a continuous confinement when in a Hospital)<br><br>**Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions** | Covered in Full | 20% Coinsurance after Deductible | 120 Days Maximum per Confinement |
| Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)<br>**Preauthorization Required** | $10 Copayment | 20% Coinsurance after Deductible | See Benefit For Description |
| Inpatient Substance Abuse Services (for a continuous confinement when in a Hospital)<br>**Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions** | Covered in Full | 20% Coinsurance after Deductible | 28 Days per Confinement, 42 days lifetime per Covered Person |
| Outpatient Substance Use Services | $10 Copayment | 20% Coinsurance after Deductible | 60 Visits per Plan Year; 20 Visits a Plan Year May Be Used For Family Counseling |
| PRESCRIPTION DRUGS | **Participating Member Responsibility for Cost-Sharing** | **Non-Participating Member Responsibility for Cost-Sharing** | **Limits** |
| **Retail Pharmacy** | | | |
| 30 Day Supply<br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br>$5 Copayment<br><br>$15 Copayment<br><br>$30 Copayment | <br>Non-Participating Provider Services Are Not Covered and You Pay Full Cost | See Benefit For Description |
| **Mail Order Pharmacy** | | | |
| Up to a 90 Day Supply<br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br>$10 Copayment<br><br>$30 Copayment<br><br>$60 Copayment | <br>Non-Participating Provider Services Are Not Covered and You Pay Full Cost | See Benefit For Description |
| | **Participating Member Responsibility for** | **Non-Participating Member Responsibility for** | |

| | Cost-Sharing | Cost-Sharing | |
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| **Adult and Pediatric Vision Care** | | | |
| • Exams | $10 Copayment | 20% Coinsurance after Deductible | One Exam and Lenses & Frames or Contacts in a 12-Month Period |
| • Lenses & Frames & Contact Lenses | $100 Allowable per Calendar Year for Either Lenses & Frames or Contact Lenses | $100 Allowable per Calendar Year for Either Lenses & Frames or Contact Lenses | |