SCHEDULE PPO B

PPO B SCHEDULE OF BENEFITS

CASEBP

COST-SHARING Deductible	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing \$250 \$750	LIMITS
Out-of-Pocket Limit Individual	\$1,000	\$1,100	
• Family	\$3,000	\$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 Primary Care Physicians and Specialists	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Office Visits (or Home Visits)	\$15 Copayment	30% 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	30% Coinsurance after Deductible	
Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	
Routine Gynecological /Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	
Mammography Screenings*	Covered in full	30% Coinsurance after Deductible	
 Sterilization Procedures for Women* 	Covered in full	0% Coinsurance after Deductible	
 Vasectomy 	\$15 Copayment	30% Coinsurance after Deductible	
Bone Density Testing*	Covered in Full	30% Coinsurance after Deductible	
Screening for Prostate Cancer	Covered in full	30% Coinsurance after Deductible	
All other preventative services required by USPSTF AND HRSA. *When preventative services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. EMERGENCY CARE	Covered in Full Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing Participating Member Responsibility for Cost-Sharing	30% Coinsurance after Deductible Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing Non-Participating Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency	\$50 Copayment	\$50 Copayment	See Benefit For

Medical Services (Ambulance			Description
Services)			Description
Services)			
Non-Emergency Ambulance	\$15 Copayment	30% Coinsurance	See Benefit For
Services	φτο σοραγιποιπ	after Deductible	Description
Preauthorization Required		ditor Boddonoro	2 ccciiption
Emergency Department	\$50 Copayment	\$50 Copayment	See Benefit For
	, , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	Description
Copayment waived if Hospital			•
admission.			
Urgent Care Center	\$25 Copayment	30% Coinsurance	See Benefit For
		after Deductible	Description
			•
PROFESSIONAL SERVICES	Participating	Non-Participating	Limits
AND OUTPATIENT CARE	Member	Member	
	Responsibility for	Responsibility for	
	Cost-Sharing	Cost-Sharing	
Advanced Imaging Services	\$15 Copayment	30% Coinsurance	See Benefit For
 Performed in a 		after Deductible	Description
Freestanding			
Radiology Facility or			
Office Setting			
5g			
	Covered in Full	30% Coinsurance	
Performed as		after Deductible	
Outpatient Hospital			
Services			
OCI VICCS			
Allergy Testing & Treatment	Covered in Full	30% Coinsurance	See Benefit For
		after Deductible	Description
Ambulatory Surgical Center	\$15 Copayment	30% Coinsurance	See Benefit For
Facility Fee	, , , ,	after Deductible	Description
			•
Anesthesia Services (all	Covered in full	30% Coinsurance	See Benefit For
settings)		after Deductible	Description
Autologous Blood Banking	\$15 Copayment	30% Coinsurance	See Benefits For
		after Deductible	Description
Preauthorization Required			
Cardiac & Pulmonary			See Benefits For
Rehabilitation	4.50		Description
 Performed in a 	\$15 Copayment	30% Coinsurance	
Specialist Office		after Deductible	
	4.5.0	000/ 0 :	
 Outpatient Hospital 	\$15 Copayment	30% Coinsurance	
Services		after Deductible	
	Covered in Full	200/ Cainaurana	
 Inpatient Hospital 	Covered in Full	30% Coinsurance	
Services		after deductible	
		1	

Characth areas	<u> </u>		Can Damasit Fan
Chemotherapy	Covered in Full	200/ Coincurance	See Benefit For
Performed in an Office	Covered in Full	30% Coinsurance after Deductible	Description
		alter Deductible	
 Performed as 	Covered in Full	30% Coinsurance	
	Covered III I dii	after Deductible	
Outpatient Hospital		arter Deductible	
Services			
Duranthanination Danishad			
Preauthorization Required	\$45 Canas mass and	000/ 0-:	0 D
Chiropractic Services	\$15 Copayment	30% Coinsurance	See Benefit For
		after Deductible	Description
Diagnostic Testing			See Benefit For
 Performed in an Office 	Covered in Full	30% Coinsurance	Description
• Fellolliled III all Office	Oovered iii i dii	after Deductible	Description
		and Deddolible	
 Performed as 	Covered in Full	30% Coinsurance	
Outpatient Hospital		after Deductible	
Services			
Services			
Dialysis			See Benefit For
Performed in an Office	Covered in Full	30% Coinsurance	Description
i onomica in an omeo	Covered III all	after Deductible	2 dodnipulom
 Performed in a 			
Freestanding Center	Covered in Full	30% Coinsurance	
or Specialist Office		after Deductible	
Setting			
	Covered in Full	30% Coinsurance	
 Performed as 		after Deductible	
Outpatient Hospital			
Services			
Habilitation Services	\$15 Copayment	30% Coinsurance	60 visits por
(Physical Therapy,	ψτο Copayinent	after Deductible	60 visits per condition combined
Occupational Therapy or		alter Deductible	therapies per Plan
Speech Therapy)			Year
Opceon merapy)			i Gai
Preauthorization Required			
Home Health Care	Covered in Full	30% Coinsurance	40 Visits per Plan
		after \$50 Deductible	Year
Preauthorization Required			
Infertility Services	\$15 Copayment	30% Coinsurance	See Benefit For
	' '	after deductible	Description
Preauthorization Required			'
Infusion Therapy			
 Performed in an Office 	Covered in Full	30% Coinsurance	See Benefit For
		after Deductible	Description

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Performed as Outpatient Hospital Services	Covered in Full	30% Coinsurance after deductible	Home Infusion counts towards 40 Home Health Care
Services	Covered in Full	30% Coinsurance	Visit Limits per Plan
Home Infusion		after Deductible	Year
Therapy			
Inpatient Medical Visits	\$15 Copayment	30% Coinsurance	See Benefit For
		after Deductible	Description
Laboratory Procedures	0	200/ 0-1	See Benefit For
Performed in an Office	Covered in Full	30% Coinsurance after Deductible	Description
 Performed 			
Freestanding	Covered in Full	30% Coinsurance after Deductible	
Laboratory Facility		arter Deductible	
	Covered in Full	30% Coinsurance	
Performed as Outpetient Heapital	Covered in Full	after Deductible	
Outpatient Hospital Services			
Maternity & Newborn Care			See Benefit For Description
Prenatal Care	Covered In Full	30% Coinsurance	Describitori
		after Deductible	
Inpatient Hospital	Covered in Full	30% Coinsurance	Home Care Visit is
Services		after Deductible	Covered at no Cost-Sharing if
Physician and Nurse	\$15 Copayment	30% Coinsurance	mother is
Midwife Services for		after Deductible	discharged from
Delivery			Hospital early
	Covered to Full	200/ Online	
Breast Pump	Covered in Full	30% Coinsurance after Deductible	
			Covered for
Preauthorization Required			duration of breast feeding
for Inpatient Services Outpatient Hospital Surgery	\$15 Copayment	30% Coinsurance	See Benefit For
Facility Charge	ψιο σοραγιπ ο πι	after Deductible	Description
Preadmission Testing	Covered in Full	30% Coinsurance	See Benefit For
		after Deductible	Description
Diagnostic Radiology			
Services • Performed in an Office	\$15 Copayment	30% Coinsurance	See Benefit For Description
• 1 GHOITHEU III AII OIIICE	Ψτο σοραγιπ ο πι	after Deductible	Description

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 Performed in a Freestanding Radiology Facility 	\$15 Copayment	30% Coinsurance after Deductible	
 Performed as Outpatient Hospital Services 	Covered in Full	30% Coinsurance After Deductible	
Therapeutic Radiology Services			See Benefit For Description
 In a Freestanding Radiology 	\$15 Copayment	30% Coinsurance after Deductible	Безоприоп
Facility/OfficePerformed as Outpatient Hospital Services	Covered in Full	30% Coinsurance after Deductible	
Preauthorization Required			
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) Preauthorization Required	\$15 Copayment	30% 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	\$15 Copayment	30% Coinsurance after Deductible Second Opinions on Diagnosis of Cancer	See Benefit For Description
Preauthorization Required		are Covered at Participating Cost- Sharing for Non- Participating Specialist	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery	Covered in Full	30% Coinsurance after Deductible	See Benefit For Description All Transplants Must be Performed at Designated Facilities.
Outpatient Hospital Surgery	\$15 Copayment	30% Coinsurance after Deductible	

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 Surgery Performed at 	\$15 Copayment	30% Coinsurance	
an Ambulatory		after Deductible	
1			
Surgical Center			
	\$15 Consument	30% Coinsurance	
 Office Surgery 	\$15 Copayment		
		after Deductible	
Preauthorization; Required			
ADDITIONAL SERVICES,	Participating	Non-Participating	Limits
EQUIPMENT & DEVICES	Member	Member	Ellints
EQUIPMENT & DEVICES			
	Responsibility for	Responsibility for	
	Cost-Sharing	Cost-Sharing	
ABA Treatment for Autism	\$15 Copayment	30% Coinsurance	680 Hours Per Plan
Spectrum Disorder		after Deductible	Year
Preauthorization Required			
Assistive Communication	\$15 Copayment	30% Coinsurance	See Benefit For
Devices for Autism Spectrum	φ το σοραγιποτία	after Deductible	Description
•		alter Deductible	Describiton
Disorder			
Preauthorization Required			
Diabetic Equipment, Supplies			See Benefit For
& Self-Management			Description
Education			See Prescription
Diabetic Equipment,	\$15 Copayment	30% Coinsurance	Drug Benefit
	ψτο σοραγιτοπι	after Deductible	Brag Borion
Supplies		and beddelible	
	See the Prescription	30% Coinsurance	
	See the Prescription		
 Insulin (30-Day 	Drug Cost-Sharing	after Deductible	
Supply)			
11 37			
	\$15 Copayment	30% Coinsurance	
		after Deductible	
Diabetic Education			
Diabetic Education			
Due out houisetiere De suries d			
Preauthorization Required	000/ 0 :	000/ 0 :	0 0 0 0
Durable Medical Equipment &	20% Coinsurance	30% Coinsurance	See Benefit For
Braces	not subject to	after Deductible	Description
	Deductible		
Preauthorization Required			
Cochlear Implants	\$15 Copayment	30% Coinsurance	One Per Ear Per
	, , ,	after Deductible	Time Covered
Preauthorization Required		55. 2 5 4 4 5 1 5 1 5	
Hospice Care			210 Dave per Plan
•	Covered in Full	200/ Coinquirence	210 Days per Plan
 Inpatient 	Covered in Full	30% Coinsurance	Year
		after Deductible	
 Outpatient 	Covered in Full	30% Coinsurance	5 Visits for Family
		after Deductible	Bereavement
			Counseling
Preauthorization Required			
Medical Supplies	20% Coinsurance	30% Coinsurance	See Benefit For
iviodiodi oupplios			
	not subject to	after Deductible	Description

	Deductible		
Prosthetic Devices	Doddolibio		
 External Internal Preauthorization Required for Prosthetics over \$1,000 	20% Coinsurance not subject to Deductible 20% Coinsurance not subject to Deductible	30% Coinsurance after Deductible 30% 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) Preauthorization Required	Covered in Full	30% Coinsurance after Deductible	See Benefit For Description
Observation Stay	Covered in Full	30% Coinsurance	See Benefit For
Preauthorization Required	Govered III I dii	after Deductible	Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	Covered in Full 45 Days SNF Only	No Coverage	45 Days Only
Preauthorization Required			
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) Preauthorization Required	Covered in Full	30% Coinsurance after Deductible	60 Consecutive Days per Condition per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	Covered in Full	30% Coinsurance after Deductible	120 Days Maximum per Confinement
Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions			

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Outpatient Mental Health	\$15 Copayment	30% Coinsurance	See Benefit For
Care (Including Partial		after Deductible	Description
Hospitalization & Intensive			
Outpatient Program Services)			
Preauthorization Required			
Inpatient Substance Abuse	Covered in Full	30% Coinsurance	28 Days per
Services (for a continuous		after Deductible	Confinement, 42
confinement when in a			days lifetime per
Hospital)			Covered Person
Preauthorization Required.			
However, Preauthorization			
is Not Required for			
Emergency Admissions			
Outpatient Substance Use	\$15 Copayment	30% Coinsurance	60 Visits per Plan
Services	ф то образители	after Deductible	Year; 20 Visits a
OCI VICCS		alter beddelible	Plan Year May Be
			Used For Family
PRESCRIPTION DRUGS	Doutioinatina	Non Doutisinstins	Counseling Limits
FRESCRIFTION DRUGS	Participating Member	Non-Participating Member	Lilling
	Responsibility for	Responsibility for	
D. (. 'I DI	Cost-Sharing	Cost-Sharing	
Retail Pharmacy			0 5 6: 5
30 Day Supply			See Benefit For
Tier 1	\$5 Copayment	Non-Participating	Description
		Provider Services	
Tier 2	\$15 Copayment	Are Not Covered and	
		You Pay Full Cost	
Tier 3	\$30 Copayment		
Mail Order Pharmacy			
Up to a 90 Day Supply			
Tier 1	\$10 Copayment	Non-Participating	See Benefit For
	-	Provider Services	Description
Tier 2	\$30 Copayment	Are Not Covered and	
		You Pay Full Cost	
Tier 3	\$60 Copayment		
	. ,	Non Doubleton (Co.	
	Participating	Non-Participating	
	Member	Member	
	Responsibility for	Responsibility for	
A shalf and Doublet 1 No. 1	Cost-Sharing	Cost-Sharing	
Adult and Pediatric Vision		000/ 0 :	
Care		30% Coinsurance	
		after Deductible	
Exams	\$15 Copayment		
		\$100 Allowable per	One Exam and
		Calendar Year for	Lenses & Frames
	\$100 Allowable per	Either Lenses &	or Contacts in a 12-
Lenses & Frames &	Calendar Year for	Frames or Contact	Month Period
Contact Lenses	Either Lenses &	Lenses Adult,	
Contact London	Frames or Contact	Deductible/30%	
	Lenses Adult, 20%	Coinsurance	
	Coinsurance for	for dependents	
	dependents under	under age 19	
	age 19	and ago to	