SCHEDULE PPO C

PPO C SCHEDULE OF BENEFITS

CASEBP

COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**LIMITS**
Deductible			
• Individual		$250	
• Family		$750	
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)	$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**

• 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	0% 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. *When preventative services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Covered in Full Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	20% Coinsurance after Deductible 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**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	$50 Copayment	$50 Copayment	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	$10 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Emergency Department 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 • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	$10 Copayment Covered in Full	20% Coinsurance after Deductible 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 **Preauthorization Required**	$10 Copayment	20% Coinsurance after Deductible	See Benefits For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Outpatient Hospital Services	$10 Copayment $10 Copayment Covered in Full	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance	See Benefits For Description

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

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

Preadmission Testing	Covered in Full	20% Coinsurance after Deductible	See Benefit For Description
Diagnostic Radiology Services • Performed in an Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	$10 Copayment $10 Copayment Covered in Full	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance After Deductible	See Benefit For Description
Therapeutic Radiology Services • In a Freestanding Radiology Facility/Office • Performed as Outpatient Hospital Services **Preauthorization Required**	$10 Copayment Covered in Full	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **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 **Preauthorization Required**	$10 Copayment	20% Coinsurance after Deductible 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 Breast Surgery; Other			See Benefit For Description

Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Preauthorization; Required**	Covered in Full $10 Copayment $10 Copayment $10 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 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 **Preauthorization Required**	$10 Copayment	20% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization Required**	$10 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • **Diabetic Equipment, Supplies** • **Insulin (30-Day Supply)** • **Diabetic Education**	$10 Copayment See the Prescription Drug Cost-Sharing $10 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description See Prescription Drug Benefit
Durable Medical Equipment & Braces **Preauthorization Required**	20% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See Benefit For Description
Cochlear Implants	$10 Copayment	20% Coinsurance	One Per Ear Per

Preauthorization Required		after Deductible	Time Covered
Hearing Aids	$10 Copayment	20% Coinsurance after Deductible	One Per Ear Per every 4 years
Hospice Care • Inpatient • Outpatient **Preauthorization Required**	Covered in Full Covered in Full	20% Coinsurance after Deductible 20% Coinsurance after Deductible	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices • External • Internal • **Preauthorization Required for Prosthetics over $1,000**	20% Coinsurance not subject to Deductible 20% Coinsurance not subject to Deductible	20% Coinsurance after Deductible 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) **Preauthorization Required**	Covered in Full	20% Coinsurance after Deductible	See Benefit For Description
Observation Stay **Preauthorization Required**	Covered in Full	20% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	Covered in Full 45 Days SNF Only	No Coverage	45 Days Only
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	Covered in Full	20% 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) **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) **Preauthorization Required**	$10 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Inpatient Substance Abuse Services (for a continuous confinement when in a Hospital) **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 Tier 1 Tier 2 Tier 3	 $10 Copayment $20 Copayment $35 Copayment	 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 Tier 1 Tier 2 Tier 3	 $20 Copayment $40 Copayment $70 Copayment	 Non-Participating Provider Services Are Not Covered and You Pay Full Cost	See Benefit For Description
	Participating Member	**Non-Participating Member**	

	Responsibility for Cost-Sharing	Responsibility for Cost-Sharing	
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	