SCHEDULE OF MEDICAL BENEFITS			
BENEFITS	***IN-NETWORK***	***OUT-OF-NETWORK***	***TEXT PAGE***
PROVIDER NETWORK	UHC Choice Plus UHC Options		
CALENDAR YEAR	January 1 – December 31		
DEDUCTIBLE Single Family	 $2,000 $4,000	 N/A N/A	1-15
COINSURANCE	100%	N/A	1-15
OUT-OF-POCKET MAXIMUM **Combined Deductible and Coinsurance** Single Family **Medical Copays** Single Family **Combined Deductible, Coinsurance and Medical Copays** Single Family *(Prescription Drug Has a Separate Out of Pocket Maximum)*	 $2,000 $4,000 $2,000 $4,000 $4,000 $8,000	 N/A N/A N/A N/A N/A N/A	1-15
Note**:** *Deductible Does Not Apply to the Medicare Carve-Out Plans.* ***Note*****:** *Embedded - Deductible and Out-of-Pocket Family Maximums are on a Combined Dollar Basis. No One Covered Person in the Family May Incur More Than the Individual Maximum per Calendar Year.*			

PHYSICIAN SERVICES			
Office Visits – Primary Care	$30 Copay per Visit, then Deductible/100%	Not Covered	1-18
Specialist Office Visits	$30 Copay per Visit, then Deductible/100%	Not Covered	
Manipulations *(Routine and Maintenance Care is Covered)*	$30 Copay per Visit, then Deductible/100%	Not Covered	1-18

HOSPITAL SERVICES	*IN-NETWORK*	*OUT-OF-NETWORK*	*TEXT PAGE*
Inpatient Hospital Services	Deductible/100%	Not Covered	1-18
Outpatient Hospital Services	Deductible/100%	Not Covered	1-22
Other Qualified Practitioner Benefits *(Inpatient and Outpatient Hospital Visits, Surgery and Anesthesia)*	Deductible/100%	Not Covered	1-18
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Office Visits	$30 Copay per Visit, then In-Network Deductible/100%		1-27
Outpatient Hospital Services	In-Network Deductible/100%		1-28
Inpatient Hospital Services	Deductible/100%	Not Covered	1-28
PREVENTIVE CARE SERVICES			
Routine Physical Exams *(Maximum of One Exam per Calendar Year) (Certain Services, Including all Lab Tests, Whether Routine or with a Diagnosis, Billed with a Routine Physical Exam may be Payable the Same as the Preventive Care Services Benefit. Office Surgeries are Excluded. Limited to 30 Days prior to or after Routine Physical Exam is Performed.)*	100%, Deductible Waived	Not Covered	1-20
Routine Lab Tests	100%, Deductible Waived	Not Covered	
Immunizations *(Routine Immunizations)*	100%, Deductible Waived		1-20
Preventive Care Exams *(Routine & Non-Routine Exams)*			
Colorectal Screenings *(Colonoscopy, Sigmoidoscopy)*	100%, Deductible Waived *(1st Exam of Calendar Year)*	Not Covered	1-35
	Deductible/100% *(Additional Exams in Calendar Year)*	Not Covered	
Fecal DNA Testing *(e.g., Cologuard)*	100%, Deductible Waived *(1st Exam of Calendar Year)* In-Network Deductible/100% *(Additional Exams in Calendar Year)*		

Preventive Care Exams *(Routine & Non-Routine Exams)*	***IN-NETWORK***	***OUT-OF-NETWORK***	***TEXT PAGE***
Hearing Exams	100%, Deductible Waived *(1st Exam of Calendar Year)* Deductible/100% *(Additional Exams in Calendar Year)*	Not Covered	1-34
Mammograms *(Includes 3D Mammograms)*		Not Covered	1-35
Pap/Pelvic Exams			1-35
Prostate Exams/PSA Tests			1-35
Vision Exams	100%, Deductible Waived *(1st Exam of Calendar Year)* In-Network Deductible/100% *(Additional Exams in Calendar Year)*		1-34
EMERGENCY/URGENT CARE SERVICES			
Ambulance Services *(Limited to Appropriate Air or Ground Transport to the Nearest Facility Equipped to Treat the Sickness or Injury.)*	In-Network Deductible/100%		1-23
Emergency Room Services *(Copay Waived if Admitted to Hospital from Emergency Room within 24 Hours.)*	$300 Copay per Visit, then In-Network Deductible/100%		1-23
Urgent Care Services	$75 Copay per Visit, then Deductible/100%	Not Covered	1-22
X-RAY & LABORATORY SERVICES			
Diagnostic Lab/X-Ray Services ***(Non-Routine)*** *(Limited to 4 Urinary Drug Screenings per Calendar Year; Emergency or Urgent Care Visits Not Included in Limit. Non-Medical Screenings Not Covered.)*	Deductible/100%	Not Covered	1-22
High Tech Imaging ***(MRI/MRA/CT/PET Scans)***	$100 Copay per Day, then Deductible/100%	Not Covered	
REHABILITATION THERAPY			
Outpatient Cardiac Rehabilitation Services *(Phase II Only. Phase III is Not Covered.)*	Deductible/100%	Not Covered	1-32
Physical, Speech, Occupational & Respiratory Therapy	$30 Copay per Visit, then Deductible/100%	Not Covered	1-32

OTHER COVERED SERVICES	*IN-NETWORK*	*OUT-OF-NETWORK*	*TEXT PAGE*
Allergy Testing/Treatment	Deductible/100%	Not Covered	1-33
Ambulatory Surgical Center	Deductible/100%	Not Covered	1-22
Birthing Center Services	Deductible/100%	Not Covered	1-24
Breast Pumps *(Maximum of $400 per Pregnancy, Including Certain Supplies, Taxes and Shipping)*	100%, Deductible Waived		1-20
Durable Medical Equipment	Deductible/100%	Not Covered	1-32
Gender Dysphoria **Travel And Lodging** *(Limited to $2,000 per Calendar Year)*	Deductible/100% Deductible/100%	Not Covered Not Covered	1-37
Health Club Reimbursement *(Maximum $120 for Single/$240 Family Coverage per Calendar Year)*	100%, Deductible Waived		1-35
Home Health Care Services	Deductible/100%	Not Covered	1-25
Hospice Care Services	Deductible/100%	Not Covered	1-25
Maternity Services	Deductible/100%	Not Covered	1-23
Oral Surgery **Other Dental Services** *(Extractions, Replacements Limited to $1,500 per Calendar Year)*	Deductible/100% Deductible/100%	Not Covered Not Covered	1-19
Pre-Admission Testing Services	Deductible/100%	Not Covered	1-33
Second Surgical Opinion	Deductible/100%	Not Covered	1-33
Skilled Nursing Facility Services *(Limited to 60 Days per Confinement)*	Deductible/100%	Not Covered	1-24
Teladoc *(Medical, Behavioral Health and Dermatology Coverage)*	100%, Deductible Waived		1-29
Telehealth **Office Visits** **Outpatient**	 $30 Copay per Visit, then Deductible/100% Deductible/100%	 Not Covered Not Covered	1-37

OTHER COVERED SERVICES	*IN-NETWORK*	*OUT-OF-NETWORK*	*TEXT PAGE*
	Center of Excellence	*Non-Center of Excellence*	
Transplants **Travel and Lodging** *(Covered Only for Centers of Excellence Transplants. Limited to $10,000 per Transplant)*	Deductible/100% 100%, Deductible Waived	Not Covered Not Covered	1-26
STATE MANDATED BENEFITS			
Blood Lead Tests ***(Not Covered Under Preventive Care Services)*** *(Covered Dependent Children under Age 6)*	Deductible/100%	Not Covered	1-40
Hearing Hardware ***(Covered Persons under Age 18)*** *(Maximum of 1 Hearing Aid per Ear every 3 Calendar Years; Cochlear Implants and Bone-Anchored Hearing Aids)*	Deductible/100%	Not Covered	1-40
Dental Services ***(Hospital or Ambulatory Surgical Services)*** *(Refer to the State Mandated Benefits Section for Details regarding this Benefit)*	Deductible/100%	Not Covered	1-40
TMJ Treatment	Deductible/100%	Not Covered	1-40
Other State Mandated Benefits	Deductible/100%	Not Covered	1-40

PRESCRIPTION DRUG CARD				*TEXT PAGE*
Drug Tier	**Retail 30 Day Supply**	**Retail 31-90 Day Supply**	**Mail Order 90 Day Supply**	1-50
Generic	$15	$45	$30	
Preferred	$45	$135	$90	
Non-Preferred	$60	$180	$120	
Specialty	$100 Maximum 30 Day Supply, Mail Order Only			
Other Prescription Drug Card Provisions	**Certain Diabetic Supplies:** $0 Copay, Deductible Waived (Test strips, lancets and needles) **Note:** If an active Employee has a spouse over age 65, both will retain the prescription drug coverage until the active Employee retires. At that time, whoever is age 65 or older will have to obtain Medicare Part D.			
Prescription Drug Out-of-Pocket Maximum Single Family	$3,000 $6,000			

LIMITATIONS & EXCLUSIONS – SEE TEXT FOR DETAILS