MEDICAL SCHEDULE OF BENEFITS

Plan(s) 011 (F)

All health benefits shown on this Schedule of Benefits are subject to the following: Lifetime and annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and Covered Benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Notification may be required before benefits will be considered for payment. Failure to obtain notification may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and notification procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	**OUT-OF-NETWORK**
Individual Lifetime Maximum Benefit	$2,000,000	
Annual Deductible Per Calendar Year:		
• Per Person	$500	$500
• Per Family	$1,500	$1,500
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	100%	80%
Annual Out-Of-Pocket Maximum:		
• Per Person	$500	Unlimited
• Per Family	$1,500	Unlimited
Acupuncture Treatment:		
• Co-pay Per Visit	$10	Not Applicable
• Maximum Visits Per Calendar Year	12 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Ambulance Transportation:		
• Paid By Plan After Deductible ***Note: Air Ambulance - Non-Emergent Transportation Requires Pre-Authorization For Clinical Eligibility. There Is No Capitation On Any Of The Plans For Emergent Transport.***	100%	100%
Chiropractic Services: **Office Visit:**		
• Co-pay Per Visit	$10	Not Applicable
• Paid By Plan	100% (Deductible Waived)	80%

	IN-NETWORK	OUT-OF-NETWORK
Manipulations:		
• Co-pay Per Visit	$10	Not Applicable
• Maximum Visits Per Calendar Year	24 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
X-rays:		
• Co-pay Per Visit	$10	Not Applicable
• Paid By Plan	100% (Deductible Waived)	80%
Durable Medical Equipment:		
• Combined Maximum Benefit Per Calendar Year	$10,000	
• Paid By Plan After Deductible	100%	80%
Note: Maximum Is A Combination Of Orthotics, Medical Supplies, Respiratory Equipment, Shoe Inserts-Custom Molded And Prosthetics.		
Emergency Services / Treatment:		
Urgent Care:		
• Co-pay Per Visit	$10	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
True Emergency Room / Emergency Physicians:		
• Paid By Plan After Deductible	100%	100%
Non-true Emergency Room / Emergency Physicians:		
• Paid By Plan After Deductible	100%	80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:		
• Maximum Days Per Calendar Year	60 Days	
• Paid By Plan After Deductible	100%	80%
Home Health Care Benefits:		
• Maximum Visits Per Calendar Year	130 Visits	
• Paid By Plan After Deductible	100%	80%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits:		
In Home Hospice Care:		
• Paid By Plan After Deductible	100%	80%
Inpatient Hospice Care:		
• Maximum Benefit Per Lifetime	10 Days	
• Paid By Plan After Deductible	100%	80%
Respite Care:		
• Maximum Benefit Per Lifetime	240 Hours	
• Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services - Except For Mental Health And Substance Abuse And Chemical Dependency:		
Pre-admission Testing:		
• Paid By Plan After Deductible	100%	80%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	100%	80%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	100%	80%
Outpatient Lab And X-ray Charges:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	100%	80%
Infusion Therapy:		
• Paid By Plan After Deductible	100%	80%
Medical Supplies:		
• Combined Maximum Benefit Per Calendar Year	$10,000	
• Paid By Plan After Deductible	100%	80%
Note: Maximum Is A Combination Of Orthotics, Durable Medical Equipment, Respiratory Equipment, Shoe Inserts-Custom Molded And Prosthetics.		
Mental Health Benefits:		
Inpatient Or Partial Hospitalization:		
• Maximum Days Per Calendar Year	14 Days	
• Paid By Plan After Deductible	100%	80%
Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day		
Outpatient Treatment:		
• Co-pay Per Visit	$10	Not Applicable
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Neuro Developmental Therapy (Includes Autism And Developmental Delays):		
Neuro Developmental Inpatient Hospital Therapy:		
• Maximum Days Per Calendar Year	30 Days	
• Paid By Plan After Deductible	100%	80%
Neuro Developmental Outpatient Hospital Therapy:		
• Maximum Visits Per Calendar Year	45 Visits	
• Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Nutrition Counseling:		
• Maximum Visits Per Calendar Year	4 Visits	
• Paid By Plan After Deductible	100%	80%
Note: Diabetes Counseling Is Unlimited.		
Orthotic Appliances:		
• Combined Maximum Benefit Per Calendar Year	$10,000	
Shoe Inserts-custom Molded:		
Included In Maximum		
• Maximum Benefit Per Calendar Year	$300	
• Paid By Plan After Deductible	100%	80%
Note: Maximum Is A Combination Of Durable Medical Equipment, Medical Supplies, Respiratory Equipment, Shoe Inserts-Custom Molded And Prosthetics.		
Physician Office Visit - Except For Mental Health, Substance Abuse And Chemical Dependency:		
Office Visit:		
• Co-pay Per Visit	$10	Not Applicable
• Paid By Plan	100% (Deductible Waived)	80%
Physician Office Services:		
• Paid By Plan After Deductible	100%	80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
From Age 24 Months		
• Maximum Benefit Per Calendar Year	$1,000	
Preventive / Routine Physical Exams:		
Included In Maximum		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Immunizations Including Flumist Vaccine:		
Included In Maximum		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Included In Maximum		
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Mammograms And Breast Exams:		
• Maximum Benefit Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Pelvic Exams And Pap Test:		
Included In Maximum		
• Maximum Benefit Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine PSA Test And Prostate Exams:		
Included In Maximum		
• Maximum Benefit Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	80%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
• Paid By Plan After Deductible	100%	80%
Preventive / Routine Care Benefits For Children Include:		
To Age 24 Months		
Preventive / Routine Physical Exams:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Immunizations Including Flumist Vaccine:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Prosthetics:		
• Combined Maximum Benefit Per Calendar Year	$10,000	
• Paid By Plan After Deductible	100%	80%
Note: Maximum Is A Combination Of Durable Medical Equipment, Medical Supplies, Respiratory Equipment, Shoe Inserts-Custom Molded And Orthotics.		
Psychological And Neuropsychological Testing:		
• Maximum Benefit Per Calendar Year	12 Hours	
• Paid By Plan After Deductible	100%	80%
RehabilitationTherapy And Chronic Pain Care:		
• Maximum Visits Per Calendar Year For Inpatient	30 Days	
• Maximum Visits Per Calendar Year For Outpatient	45 Visits	
Occupational / Physical / Speech Outpatient Hospital Therapy And Cardiac And Pulmonary Rehabilitation:		
Included In Maximum		
• Paid By Plan After Deductible	100%	80%

	IN-NETWORK	OUT-OF-NETWORK
Occupational / Physical / Speech Office Therapy: Included In Maximum • Co-pay Per Visit • Paid By Plan After Deductible ***Note: Inpatient Care Must Start Within 24 Months From Onset Of The Illness Or Injury For Rehab (DNA To Pain Care).***	 $10 100% (Deductible Waived)	 Not Applicable 80%
Respiratory Equipment: • Combined Maximum Benefit Per Calendar Year • Paid By Plan After Deductible ***Note: Maximum Is A Combination Of Durable Medical Equipment, Medical Supplies, Prosthetics, Shoe Inserts-Custom Molded And Orthotics.***	 $10,000 100%	 80%
Services In A Country Outside Of The United States: • Paid By Plan After Deductible	100%	100%
Substance Abuse And Chemical Dependency Benefits: • Maximum Benefit Per 24 Months • Maximum Benefit Per Lifetime **Inpatient Or Partial Hospitalization:** Included In Maximum • Paid By Plan After Deductible ***Note: Two Days Of Partial Hospitalization Will Reduce Inpatient Maximum By One Day. Services Provided In The Emergency Room Or As Inpatient Hospitalization For Chemical Dependency Detoxification Does Not Accrue Toward The Maximum.*** **Outpatient Treatment:** Included In Maximum • Co-pay Per Visit • Paid By Plan After Deductible	 $16,380 $32,750 100% $10 100% (Deductible Waived)	 80% Not Applicable 80%
All Other Covered Expenses: • Paid By Plan After Deductible	100%	80%

TRANSPLANT SCHEDULE OF BENEFITS Plan(s) 010(F)		
	IN-NETWORK	**OUT-OF-NETWORK**
Effective Upon Receipt Of Signed URN Documents **Transplant Services At A Designated Transplant Facility:** **Transplant Services:** • Maximum Benefit Per Lifetime • Paid By Plan After Deductible **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan After Deductible ***Note: Maximum Benefit Is Limited To Recipients Living More Than 50 Miles From Transplant Center. If Recipient Is A Minor Child, Expenses For Recipient And Two Companions Cover Up To $125 Per Day. If Recipient Is Not A Minor Child, Expenses Are Covered Up To $80 Per Day.***	 $250,000 100% $7,500 100%	
Transplant Services At A Non-designated Transplant Facility: **Transplant Services:** • Maximum Benefit Per Lifetime • Paid By Plan After Deductible ***Note: Maximum Benefit Begins 30 Days Before Transplant.*** **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan After Deductible ***Note: Maximum Benefit Is Limited To Recipients Living More Than 50 Miles From Transplant Center. If Recipient Is A Minor Child, Expenses For Recipient And Two Companions Cover Up To $125 Per Day. If Recipient Is Not A Minor Child, Expenses Are Covered Up To $80 Per Day.*** **Donor Services – Acquisition And Procurement Costs:** • Maximum Benefit Per Transplant • Paid By Plan After Deductible	 $250,000 100% $7,500 100% $75,000 100%	No Benefit

PRESCRIPTION SCHEDULE OF BENEFITS INNOVIANT Plan(s) 011(F)	
Annual Prescription Smoking Deterrent Products Maximum • Per Person Per Calendar Year	 $250
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Products Preferred Brand Products	 For Up To A 34-Day Supply: $10 $20
Retail 90 Rx By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Products Preferred Brand Products	 For Up To A 3 Month Supply: (At Least 84 Days) $30 $60
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Generic Products Preferred Brand Products	 For Up To A 90-Day Supply: $25 $50
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products Preferred Brand Products	 For Up To A 34-Day Supply $10 $20
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To Innoviant For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.

DENTAL SCHEDULE OF BENEFITS

Benefit Plan 001

Benefits for You and Your Dependents are listed below.

SUMMARY OF BENEFITS		
Deductibles Per Plan Year • Combined Basic Services and Major Services	Individual $50	Family $150
Maximums • Plan Year Benefit Maximum includes Preventive and Diagnostic Services, Basic Services, and Major Services Lifetime Orthodontic Maximum	Individual $2,000 $1,500	Family
Participation Percentage • Preventive and Diagnostic Services (Deductible waived) • Basic Services • Major Services • Orthodontic Services (Deductible waived)	**The Plan Pays** 100% 80% 50% 50%	

Limitations of Coverage:

If You and/or Your Dependents apply for coverage as a Late Enrollee, covered benefits during the first 6 months of coverage include Accidental Dental Injuries and Preventive and Diagnostic Services. Covered Persons will be eligible for Basic Services after they have been on the Plan for 6 months, Major Services after they have been on this Plan for 12 months, and eligible for Orthodontic Services following 24 months of coverage under this Plan.

VISION SCHEDULE OF BENEFITS VSP Plan(s) 011(F)	
Eye Exam • Covered Person's Co-pay Amount Every 12 Months	 $10
Prescription Glasses • Covered Person's Co-pay Amount Lenses Every 12 Months	 $25
Prescription Glasses • Covered Person's Co-pay Amount Frames Every 24 Months Allowance for Frame Amount Over Allowance	 $130 20% Off
Contact Lens Care • Covered Person's Co-pay Amount Every 12 Months Allowance for Contact Lens and Exam **Note: If you choose contact leases you will be eligible for a frame 12 months from the date the contact leases were obtained.**	 $130

EMPLOYER PAID LIFE AND AD&D INSURANCE SCHEDULE OF BENEFITS UNUM Plan(s) 011(F)	
Employee & Dependent Coverage Amounts • Employee • Dependent	$60,000 $5,000 Spouse and $2,000 Child (Live Birth to 14 Days $1,000; 14 Days to 6 Months $1,000; 6 Months to 19 Years; 26 Years if Full-Time Student $2,000)
AD&D Benefit Schedule:	Full Benefit Amount is Paid for Loss of: Life Both Hands or Both Feet or Sight of Both Eyes One Hand and One Foot One Hand and the Sight of One Eye One Foot and The Sight of One Eye Speech and Hearing

EMPLOYER PAID SHORT TERM DISABILITY INSURANCE SCHEDULE OF BENEFITS UNUM	
Weekly Benefit Amount	If You Meet the Definition of Disability, You Would be Eligible to Receive a Weekly Benefit Equal to 60% of Your Weekly Earnings, to a Maximum of $2,500 Per Week.
Definition of Disability	You Are Disabled When Unum Determines that: You are Limited From Performing the Material and Substantial Duties of Your Regular Occupation Due to Your Sickness or Injury; and You Have a 20% or More Loss in Weekly Earnings Due to the Same Sickness or Injury.
Benefit Duration	If You Meet the Definition of Disability You May Receive a Benefit for 13 Weeks.

EMPLOYER PAID LONG TERM DISABILITY INSURANCE SCHEDULE OF BENEFITS UNUM	
Benefit Amount	60% of Your Monthly Earnings To a Maximum of $7,500
Definition of Disability	You Would be Considered Disabled and Eligible for Benefits Because of Sickness or Injury if: You are Limited From Performing the Material and Substantial Duties of Your Regular Occupation; and You Have a 20% or More Loss in Indexed Monthly Earnings Due to the Same Sickness or Injury.
Survivor Benefit	Unum Will Pay Your Eligible Survivor a Lump Sum Benefit Equal to 3 Months of Your Gross Disability Payment.