SCHEDULE OF MEDICAL BENEFITS - AA Traditional Blue 901 00418019 00418020, 00418058 (DBC) and 00418068 (DBC) 00A6			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$150	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$300	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	100%	90%	100%	N/A	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital – Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	N/A	
Hospital – Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required..
Hospital – Inpatient Mental Health Residential Treatment	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital – Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital – Urgent Care Center	100%	Not covered	100%	N/A	
Hospital – All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy – Physician's Office	N/A	N/A	N/A	80%*	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy – Mental Health/Substance Abuse	100%	90%	100%	N/A	
Outpatient- Mental Health Crisis Intervention	N/A	N/A	N/A	100%	
Outpatient Therapy – Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Skilled Nursing Facility Visit	N/A	N/A	N/A	80%*	
Physician – Inpatient Surgeon	100%	90%	100%	N/A	
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician – Office Surgeon	100%	90%	100%	N/A	
Physician – Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Post-Mastectomy External Prosthetic	100%	100%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	100%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	100%	100%	N/A	Limited to 4 per calendar year.
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	80%*	
Radiation Therapy	100%	90%	100%	N/A	
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – AA Class 00418019, 00418020, 00418058 (DBC), 00418068 (DBC) 00A6 Co-Pay Option: $$10/$25/$25			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$10	$10	
Tier 2 Drug Co-pay	$25	$25	
Tier 3 Drug Co-pay	$25	$25	
Maximum Supply	30 Days	90 Days	