SCHEDULE OF MEDICAL BENEFITS – AB Traditional Blue POS 202 00418019 00418020 00418058 (DBC) 00418068 (DBC) 00B7			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$15	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
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	$2,000	Includes deductible and coinsurance amounts. 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. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $15 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance - Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $15 co-pay	80%*	Precertification is required.
Artificial Insemination - Physician	100% after $15 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $15 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $15 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $15 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $15 co-pay	80%*	
Chiropractic Care - Physician	100% after $15 co-pay	80%*	
Diabetic Education	100% after $8 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $8 co-pay	80%*	
Diagnostic Laboratory Testing	100%	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment. Limited to $1,000 per year.
Fetal Non-Stress Test	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $15 co-pay	80%*	The co-pay is waived for early maternity discharge. Out-of-Network benefits are limited to 365 visits, reduced by In-Network visits.
Home Care-Respiratory Therapy	100% after $15 co-pay	Not covered	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	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 Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $15 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $15 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $15 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $15 co-pay	80%*	Co-pay only applies when injectable medication is the only service billed.
Maternity Care	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100%	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $15 co-pay	80%*	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission. Out-of-network benefits will be paid at the in-network benefit level when related services are in-network.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day. Out-of-network benefits will be paid at the in-network benefit level when related services are in-network.
Physician – Inpatient Surgeon	100%	80%*	
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	
Physician – Office Surgeon	100% after $15 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	Out-of-Network will be paid at In-Network when related services are In-Network.
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $15 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $15 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $15 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $15 co-pay	80%*	
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $15 co-pay	80%*	
Transfusion	100% after $15 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – AB Class 00418019, 00418020, 00418058 (DBC), 00418068 (DBC) 00B7 Co-Pay Option: $$10/$25/$25			
	Pharmacy Or Mail Order	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$10	$30	
Tier 2 Drug Co-pay	$25	$75	
Tier 3 Drug Co-pay	$25	$75	
Maximum Supply	30 Days	90 Days	