SUBLUE AND SUORANGE: SCHEDULE OF BENEFITS
EMPLOYEE COST SHARING

	SUBlue (Levels One, Two, and Three)			SUOrange
	Level One POMCO/PHCS/ MultiPlan With Referral, and All Eligible International Claims	**Level Two POMCO/PHCS/ MultiPlan Without Referral**	**Level Three Out of Network**	**Level One POMCO/PHCS/ MultiPlan With Referral**
Cost Sharing Definitions				
Annual Deductible[1]	No deductible	No deductible	$300 per individual with a maximum of $1,000 family	No deductible
Coinsurance	No coinsurance	10% allowable amount	30% allowable amount plus the difference between submitted charge and the allowable amount *(exceptions noted below)*	No coinsurance
Annual Out-of-Pocket Maximum[2]	$2,000 per individual with a maximum of $4,000 for a family	$4,000 per individual with a maximum of $8,000 for a family	$6,000 per individual with a maximum of $12,000 for a family	$2,000 per individual with a maximum of $4,000 for a family
Your Institutional Covered Services				
INPATIENT HOSPITAL				
Inpatient hospital	$350 copay per admission	$350 copay per admission plus coinsurance	Deductible, $350 copay per admission, and coinsurance	$350 copay per admission
Nursery care	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
OUTPATIENT HOSPITAL				
Surgery	$200 copay	$200 copay plus coinsurance	Deductible, $200 copay, and coinsurance	$200 copay

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Pre-surgical testing	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Routine mammography screenings *(one per calendar year for ages 35 and older with exceptions if high risk)*	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full
Routine prostate cancer screenings *(one per calendar year for ages 50 and older with exceptions if high risk)*	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full
Routine cervical cancer screenings *(one per calendar year for ages 18 and older)*	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full
Colonoscopies	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full
Diagnostic machine tests, x-rays, and radiology services *(including MRIs, PET and CT scans)*	$40 copay	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$40 copay
Diagnostic laboratory tests	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Occupational therapy *(for situations not covered through a governmental program)*	$25 copay	$25 copay plus coinsurance	Deductible, $25 copay, and coinsurance	$25 copay

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	Level One POMCO/PHCS/ MultiPlan With Referral, and All Eligible International Claims	**Level Two POMCO/PHCS/ MultiPlan Without Referral**	**Level Three Out of Network**	**Level One POMCO/PHCS/ MultiPlan With Referral**
Physical Therapy	$25 copay	$25 copay plus coinsurance	Deductible, $25 copay, and coinsurance	$25 copay
Speech therapy *(for situations not covered through a governmental program)*	$25 copay	$25 copay plus coinsurance	Deductible, $25 copay, and coinsurance	$25 copay
Respiratory, radiation, cardiac therapies and chemotherapy	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
HOSPITAL EMERGENCY ROOM				
Hospital emergency Room	$150 copay	$150 copay	$150 copay	$150 copay *(includes out of network coverage)*
ADDITIONAL INSTITUTIONAL PROVIDERS				
Ambulatory surgery center	$150 copay	$150 copay plus coinsurance	Deductible, $150 copay, and coinsurance	$150 copay
Birth Center	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Skilled nursing facility *(180 inpatient days)*	$350 copay per admission	$350 copay per admission plus coinsurance	Deductible, $350 copay per admission, and coinsurance	$350 copay per admission
Home health agency	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Hospice	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full

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	Level One POMCO/PHCS/ MultiPlan With Referral, and All Eligible International Claims	**Level Two POMCO/PHCS/ MultiPlan Without Referral**	**Level Three Out of Network**	**Level One POMCO/PHCS/ MultiPlan With Referral**
Inpatient mental health disorder care *(facility charge)* • **General hospital or psychiatric facility** • **Partial hospitalization**	$350 copay per admission A separate copay will apply to partial hospitalization if the patient is discharged to a new facility after inpatient hospitalization.	$350 copay per admission plus coinsurance A separate copay will apply to partial hospitalization if the patient is discharged to a new facility after inpatient hospitalization.	Deductible, $350 copay per admission, and coinsurance A separate copay will apply to partial hospitalization if the patient is discharged to a new facility after inpatient hospitalization.	$350 copay per admission A separate copay will apply to partial hospitalization if the patient is discharged to a new facility after inpatient hospitalization.
Inpatient substance use disorder detoxification and rehabilitation • **General hospital or certified alcohol/ substance abuse facility program** • **Partial hospitalization**	$350 copay per admission; A separate copay will apply to partial hospitalization if the patient is discharged to a new facility after inpatient hospitalization.	$350 copay per admission plus coinsurance; A separate copay will apply to partial hospitalization if the patient is discharged to a new facility after inpatient hospitalization.	Deductible, $350 copay per admission, and coinsurance; A separate copay will apply to partial hospitalization if the patient is discharged to a new facility after inpatient hospitalization.	$350 copay per admission; A separate copay will apply to partial hospitalization if the patient is discharged to a new facility after inpatient hospitalization.
Outpatient treatment for substance use disorders	$40 copay	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$40 copay
Your Professional Provider Covered Services				
Surgery and assistance at surgery	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Breast reconstruction surgery	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full

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	Level One POMCO/PHCS/ MultiPlan With Referral, and All Eligible International Claims	**Level Two POMCO/PHCS/ MultiPlan Without Referral**	**Level Three Out of Network**	**Level One POMCO/PHCS/ MultiPlan With Referral**
Second opinion	No copay; paid in full	No copay; paid in full	Deductible *plus the difference between submitted charge and allowable amount*	No copay; paid in full
Anesthesia	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Maternity	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
PROFESSIONAL PROVIDER INPATIENT VISITS				
Inpatient hospital visits by physician or other professional provider	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Inpatient substance use disorder hospital visits by physician or other professional provider	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Inpatient skilled nursing facility visits by physician or other professional provider	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full

	SUBlue (Levels One, Two, and Three)			SUOrange
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Inpatient mental health disorder care visits by physician or other professional provider	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
PROFESSIONAL PROVIDER VISITS				
Office visits	$25 copay (PCP) or $40 copay (Specialist)	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$25 copay (PCP) or $40 copay (Specialist)
Well child visits • **Birth to 2nd birthday - 9 visits** • **2nd birthday to 7th birthday - 5 visits** • **7th birthday to 19th birthday - 1 visit per calendar year**	No copay; paid in full	No copay; paid in full	Deductible *plus the difference between submitted charge and allowable amount*	No copay; paid in full
Routine physical *(one per calendar year)*	No copay; paid in full	No copay; paid in full	Deductible *plus the difference between submitted charge and allowable amount*	No copay; paid in full
Routine cervical cancer screening *(annual routine pap smear)*	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full

SUBLUE AND SUORANGE: SCHEDULE OF BENEFITS
EMPLOYEE COST SHARING

	SUBlue (Levels One, Two, and Three)			SUOrange
	Level One POMCO/PHCS/ MultiPlan With Referral, and All Eligible International Claims	**Level Two POMCO/PHCS/ MultiPlan Without Referral**	**Level Three Out of Network**	**Level One POMCO/PHCS/ MultiPlan With Referral**
Allergy testing and treatment	$25 copay (PCP) or $40 copay (Specialist)	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$25 copay (PCP) or $40 copay (Specialist)
Consultation service, office	$40 copay (Specialist)	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$40 copay (Specialist)
Consultation service, hospital	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Urgent care	$50 copay	$50 copay plus coinsurance	Deductible, $50 copay, and coinsurance	$50 copay
Kidney Dialysis *(with ESRD, member must sign up for Medicare upon becoming eligible)*	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Outpatient treatment for mental health disorders *(1 therapy visit per day)*	$40 copay (Specialist)	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$40 copay (Specialist)
Private duty nursing	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Diabetes education	$25 copay (PCP) or $40 copay (Specialist)	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$25 copay (PCP) or $40 copay (Specialist)

SUBlue and SUOrange: Schedule of Benefits
Employee Cost Sharing

	SUBlue (Levels One, Two, and Three)			SUOrange
	Level One POMCO/PHCS/ MultiPlan With Referral, and All Eligible International Claims	**Level Two POMCO/PHCS/ MultiPlan Without Referral**	**Level Three Out of Network**	**Level One POMCO/PHCS/ MultiPlan With Referral**
Acupuncture	$40 copay	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$40 copay
Chiropractic services	$40 copay	No Coverage	No Coverage	$40 copay
Routine vision exam *(one exam in 24 consecutive months)*	$40 copay (Specialist)	No Coverage	No Coverage	$40 copay (Specialist)
Routine hearing exam *(one exam in 24 consecutive months)*	$40 copay (Specialist)	No Coverage	No Coverage	$40 copay (Specialist)
THERAPY				
Occupational therapy *(for situations not covered through a governmental program)*	$25 copay	$25 copay plus coinsurance	Deductible, $25 copay, and coinsurance	$25 copay
Physical therapy	$25 copay	$25 copay plus coinsurance	Deductible, $25 copay, and coinsurance	$25 copay
Speech therapy *(for situations not covered through a governmental program)*	$25 copay	$25 copay plus coinsurance	Deductible, $25 copay, and coinsurance	$25 copay

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	Level One POMCO/PHCS/ MultiPlan With Referral, and All Eligible International Claims	**Level Two POMCO/PHCS/ MultiPlan Without Referral**	**Level Three Out of Network**	**Level One POMCO/PHCS/ MultiPlan With Referral**
Respiratory, radiation, and cardiac therapies and chemotherapy	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
DIAGNOSTIC SERVICES				
Diagnostic machine tests, x-rays and radiology services *(including MRIs, PET and CT scans)*	$40 copay	$40 copay plus coinsurance	Deductible, $40 copay, and coinsurance	$40 copay
Diagnostic laboratory	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Routine mammography screenings *(one per calendar year for ages 35 and older with exceptions if high risk)*	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full
Routine prostate cancer screenings *(one per calendar year for ages 50 and older with exceptions if high risk)*	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full
Routine cervical cancer screenings *(one per calendar year for ages 18 and older)*	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full
Colonoscopies	No copay; paid in full	No copay; paid in full	Deductible and coinsurance	No copay; paid in full

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Additional Health Services				
Ambulance	$100 copay	$100 copay	$100 copay	$100 copay (includes out of network coverage)
Diabetic equipment and supplies	$20 copay	$20 copay plus coinsurance	Deductible, $20 copay, and coinsurance	$20 copay
Durable medical equipment	10% allowable amount	20% allowable amount	Deductible and 40% allowable amount *plus the difference between submitted charge and allowable amount*	10% allowable amount
Breastfeeding Equipment Rental or Purchase	No copay; paid in full	No copay; paid in full	Rental Coverage Only: Deductible and 40% of allowable amount plus the difference between the actual charge and the Allowed Charge.	No copay; paid in full

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Hearing Aids ***Across All Levels: Maximum benefit of $750 for a single hearing aid and $1,500 for binaural hearing aids; limited to once every three years***	•**Contracted Model:** 50% of the billed charge or the allowable amount (whichever is lesser) •**Non-Contracted Model**: 50% of the billed charge or the allowable amount (whichever is lesser) *plus the difference between the actual charge and the allowable amount.*	•**Contracted Model:** 50% of the billed charge or the allowable amount (whichever is lesser) •**Non-Contracted Model:** 50% of the billed charge or the allowable amount (whichever is lesser) *plus the difference between the actual charge and the allowable amount.*	Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) *plus the difference between the actual charge and the allowable amount*.	• **Contracted Model:** 50% of the billed charge or the allowable amount (whichever is lesser) • **Non-Contracted Model**: 50% of the billed charge or the allowable amount (whichever is lesser) *plus the difference between the actual charge and the allowable amount.*
Medical supplies	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Prosthetic devices	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Medical Evacuation	No Coverage	No Coverage	No Coverage	No Coverage
Repatriation	No Coverage	No Coverage	No Coverage	No Coverage
Prescription Drugs	Claims processed by prescription benefit manager.			

[1] Level Three coverage requires the employee to pay an annual deductible before any other cost sharing is determined. The annual deductible is $300 per individual with a maximum of $1,000 for a family. After the annual deductible is satisfied, the employee must pay the copay, if applicable. The coinsurance is then applied to the balance of the allowable amount. The employee is also responsible for the difference between the submitted charge and the allowable amount as

defined by POMCO.

[2] Out-of-pocket maximum refers to the maximum amount of out-of-pocket expenses an employee would pay in a calendar year. The out-of-pocket expenses are defined as the deductibles, coinsurance, and copayment amounts, exclusive of coinsurance amounts for prescription medicines. The differences between submitted charges and the allowable amounts under level three are not subject to the out-of-pocket maximum.

Each medical program is governed by the plan document. If there is any difference between the information on these summary sheets and the plan document, the plan document will rule.

Prescription Drugs	
Annual Deductible	No Deductible
Out-of-Pocket Maximum	$2,000 per individual with a maximum of $4,000 for a family
Retail: Generic	20% coinsurance*
Retail: Brand Formulary	25% coinsurance
Retail: Brand Non-Formulary	45% coinsurance
Mail Order: Generic	$20*
Mail Order: Brand Formulary	$50
Mail Order: Brand Non-Formulary	$90
Specialty Mail Order (All)	Same as Mail Order except 30 day supply
Contraceptives	Follows above schedule for retail and mail order

* ***Generic Prescription Drugs: $0 copay (Certain Age, Gender and Other Restrictions Apply)***

Aspirin
Breast Cancer Prevention Drugs
FDA-Approved Tobacco Cessation Drugs and OTC Products
Fluoride
Folic Acid
Iron Supplements
Preparatory Prescriptions for Colonoscopies
Vitamin D Supplements
Women's Contraceptives