SUPRO: SCHEDULE OF BENEFITS
EMPLOYEE COST SHARING

	SU Pro (In Network and Out of Network)	
	In Network POMCO/PHCS/Multiplan and All Eligible International Claims	**Out of Network**
Cost Sharing Definitions		
Annual Deductible[1]	$200 per individual with a maximum of $400 for a family	$300 per individual with a maximum of $1,000 for a family
Coinsurance	5% of allowable amount for inpatient hospitalization - or - 50% of allowable amount for hearing aids - or - 20% of allowable amount for all other services All preventive services covered in full	5% of allowable amount for inpatient hospitalization - or - 30% of allowable amount for all other services - plus - Difference between submitted charge and allowable amount
Annual Out-of-Pocket Maximum[2]	$1,500 per individual with a maximum of $3,000 for a family	$6,000 per individual with a maximum of $12,000 for a family
Your Institutional Covered Services		
INPATIENT HOSPITAL		
Inpatient hospital	Deductible plus coinsurance	Deductible plus coinsurance
Nursery care	Deductible plus coinsurance	Deductible plus coinsurance
OUTPATIENT HOSPITAL		
Surgery	Deductible plus coinsurance	Deductible plus coinsurance
Pre-surgical testing	Deductible plus coinsurance	Deductible plus coinsurance
Routine mammography screenings ***(one per calendar year for ages 35 and older with exceptions if high risk)***	No coinsurance; paid in full	Deductible plus coinsurance
Routine prostate cancer screenings ***(one per calendar year for ages 50 and older with exceptions if high risk)***	No coinsurance; paid in full	Deductible plus coinsurance

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Routine cervical cancer screenings ***(one per calendar year for ages 18 and older)***	No coinsurance; paid in full	Deductible plus coinsurance
Colonoscopies	No coinsurance; paid in full	Deductible plus coinsurance
Diagnostic machine tests, x-rays, and radiology services (including MRIs, PET and CT scans)	Deductible plus coinsurance	Deductible plus coinsurance
Diagnostic laboratory tests	Deductible plus coinsurance	Deductible plus coinsurance
Occupational therapy ***(for situations not covered through a governmental program)***	Deductible plus coinsurance	Deductible plus coinsurance
Physical therapy	Deductible plus coinsurance	Deductible plus coinsurance
Speech therapy ***(for situations not covered through a governmental program)***	Deductible plus coinsurance	Deductible plus coinsurance
Respiratory, radiation, cardiac therapies and chemotherapy	Deductible plus coinsurance	Deductible plus coinsurance
HOSPITAL EMERGENCY ROOM		
Hospital emergency room	Deductible plus coinsurance	In-network deductible plus in-network coinsurance
ADDITIONAL INSTITUTIONAL PROVIDERS		
Ambulatory surgery center	Deductible plus coinsurance	Deductible plus coinsurance
Birth center	Deductible plus coinsurance	Deductible plus coinsurance
Skilled nursing facility ***(180 inpatient days)***	Deductible plus coinsurance	Deductible plus coinsurance
Home health agency	Deductible plus coinsurance	Deductible plus coinsurance

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Hospice	Deductible plus coinsurance	Deductible plus coinsurance
Inpatient mental health disorder care *(facility charge)* • **General hospital or psychiatric facility** • **Partial hospitalization**	Deductible plus coinsurance	Deductible plus coinsurance
Inpatient substance use disorder detoxification and rehabilitation • **General hospital or certified alcohol/ substance abuse facility program** • **Partial hospitalization**	Deductible plus coinsurance	Deductible plus coinsurance
Outpatient treatment for substance use disorders	Deductible plus coinsurance	Deductible plus coinsurance
Your Professional Provider Covered Services		
Surgery and assistance at surgery	Deductible plus coinsurance	Deductible plus coinsurance
Breast reconstruction surgery	Deductible plus coinsurance	Deductible plus coinsurance
Second opinion	Deductible plus coinsurance	Deductible plus coinsurance
Anesthesia	Deductible plus coinsurance	Deductible plus coinsurance
Maternity	No coinsurance; paid in full	Deductible plus coinsurance
PROFESSIONAL PROVIDER INPATIENT VISITS		
Inpatient hospital visits by physician or other professional provider	Deductible plus coinsurance	Deductible plus coinsurance
Inpatient substance use disorder hospital visits by physician or other professional provider	Deductible plus coinsurance	Deductible plus coinsurance

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Inpatient skilled nursing facility visits by physician or other professional provider	Deductible plus coinsurance	Deductible plus coinsurance
Inpatient mental health disorder care visits by physician or other professional provider	Deductible plus coinsurance	Deductible plus coinsurance
PROFESSIONAL PROVIDER VISITS		
Office visits	Deductible plus coinsurance	Deductible plus coinsurance
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 coinsurance; paid in full	Deductible plus coinsurance
Routine physical ***(one per calendar year)***	No coinsurance; paid in full	Deductible plus coinsurance
Routine cervical cancer screening ***(annual routine pap smear; one per calendar year)***	No coinsurance; paid in full	Deductible plus coinsurance
Allergy testing and treatment	Deductible plus coinsurance	Deductible plus coinsurance
Consultation service, office	Deductible plus coinsurance	Deductible plus coinsurance
Consultation service, hospital	Deductible plus coinsurance	Deductible plus coinsurance
Urgent care	Deductible plus coinsurance	Deductible plus coinsurance
Kidney dialysis ***(with ESRD, member must sign up for Medicare upon becoming eligible)***	Deductible plus coinsurance	Deductible plus coinsurance
Outpatient treatment for mental health disorders	Deductible plus coinsurance	Deductible plus coinsurance
Private duty nursing	Deductible plus coinsurance	Deductible plus coinsurance

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Diabetes education	Deductible plus coinsurance	Deductible plus coinsurance
Acupuncture	Deductible plus coinsurance	Deductible plus coinsurance
Chiropractic services	Deductible plus coinsurance	Deductible plus coinsurance
Routine vision exam ***(one exam in 24 consecutive months)***	Deductible plus coinsurance	Deductible plus coinsurance
Routine hearing exam ***(one exam in 24 consecutive months)***	Deductible plus coinsurance	Deductible plus coinsurance
THERAPY		
Occupational therapy ***(for situations not covered through a governmental program)***	Deductible plus coinsurance	Deductible plus coinsurance
Physical therapy	Deductible plus coinsurance	Deductible plus coinsurance
Speech therapy ***(for situations not covered through a governmental program)***	Deductible plus coinsurance	Deductible plus coinsurance
Respiratory, radiation, and cardiac therapies and chemotherapy	Deductible plus coinsurance	Deductible plus coinsurance
DIAGNOSTIC SERVICES		
Diagnostic machine tests, x-rays and radiology services ***(including MRIs, PET and CT scans)***	Deductible plus coinsurance	Deductible plus coinsurance
Diagnostic laboratory	Deductible plus coinsurance	Deductible plus coinsurance
Routine mammography screenings ***(one per calendar year for ages 35 and older with exceptions if high risk)***	No coinsurance; paid in full	Deductible plus coinsurance
Routine prostate cancer screenings ***(one per calendar year for ages 50 and older with exceptions if high risk)***	No coinsurance; paid in full	Deductible plus coinsurance

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Routine cervical cancer screenings ***(one per calendar year for ages 18 and older)***	No coinsurance; paid in full	Deductible plus coinsurance
Colonoscopies	No coinsurance; paid in full	Deductible plus coinsurance
Additional Health Services		
Ambulance	Deductible plus coinsurance	In-network deductible plus in-network coinsurance
Diabetic equipment and supplies	Deductible plus coinsurance	Deductible plus coinsurance
Durable medical equipment	Deductible plus coinsurance	Deductible plus coinsurance
Breastfeeding Equipment Rental or Purchase	No coinsurance; paid in full	Rental Coverage Only: Deductible plus coinsurance
Hearing Aids ***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 submitted charge or the allowable amount (whichever is lesser) • **Non-Contracted Model:** 50% of the submitted charge or the allowable amount (whichever is lesser) plus the difference between the submitted charge and the allowable amount.	Deductible and 50% of the submitted charge or the allowable amount (whichever is lesser) plus the difference between the submitted charge and the allowable amount.
Medical supplies	Deductible plus coinsurance	Deductible plus coinsurance
Prosthetic devices	Deductible plus coinsurance	Deductible plus coinsurance
Medical Evacuation	No Coverage	No Coverage
Repatriation	No Coverage	No Coverage
Prescription Drugs	Claims processed by prescription benefit manager	

[1] Coverage requires the employee to pay an annual deductible before any other cost sharing is determined. The annual in-network deductible is $200 per individual with a maximum of $400 for a family. The annual out-of-network 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 coinsurance, if applicable. The coinsurance is then applied to the balance of the allowable amount. For out-of-network services, 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 and coinsurance amounts, exclusive of coinsurance amounts for prescription medicines. The differences between submitted charges and the allowable amounts under the out-of-network level 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	$2000 single/$4000 family
Retail Generic	15% coinsurance*
Retail Brand Formulary	25% coinsurance
Retail Brand Non-Formulary	40% coinsurance
Mail Generic	Lesser of $15 or 15% coinsurance*
Mail Brand Formulary	Lesser of $45 or 25% coinsurance
Mail Brand Non-Formulary	Lesser of $90 or 40% coinsurance
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