MEDICAL SCHEDULE OF BENEFITS: $750 PLAN

$750 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE		
Single	$750	$3,000
Family	$1,500	$6,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance)		
Single	N/A	$2,000
Family	N/A	$4,000
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	$8,150	Unlimited
Family	$16,300	Unlimited
MEDICAL BENEFITS		
Ambulance Services	100% after Deductible	Paid at the Participating Provider level of benefits
Chiropractic Care/Spinal Manipulation	$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	100% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	100% after Deductible	50% after Deductible
Emergency Services/Emergency Room Services	$200 Copay, then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Foot Orthotics	100% after Deductible	50% after Deductible
Plan Year Maximum Benefit	1 orthotic per foot	
NOTE: Plan Year maximum does not apply to foot orthotics for diabetes.		
Home Health Care	100% after Deductible	50% after Deductible
Hospice Care	100% after Deductible	50% after Deductible

$750 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after Deductible	50% after Deductible
Room and Board Allowance	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100% after Deductible	50% after Deductible
Outpatient	100% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	100% after Deductible	50% after Deductible
Outpatient (includes Telemedicine)	$25 Copay, then 100%; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Morbid Obesity	Paid based on place of service	Paid based on place of service
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Supplements	100%; Deductible waived	50% after Deductible
Occupational Therapy (Outpatient) (OT)	$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physical Therapy (Outpatient) (PT)	$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physician's Services		
Inpatient/Outpatient Services	100% after Deductible	50% after Deductible
Office Visit Charge & Telemedicine	$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During an Office Visit	100% after Deductible	50% after Deductible
Physician Office Surgery	100% after Deductible	50% after Deductible
NOTE: The Copay will be waived for services rendered at OB-GYN Associates of Erie, P.C. (TIN 25-1653555) and Primary Care Associates of Erie (TIN 25-1653555).		

$750 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Private Duty Nursing	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	240 hours	
Regenexx Stem Cell Treatment (received by Regenexx Corporate Provider Network only)	100%; Deductible waived	N/A
Respiratory/Pulmonary Therapy	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	20 visits	
Retail Clinic		
Retail Clinic Visit	$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100% after Deductible	50% after Deductible
Combined Plan Year Maximum Benefit	N/A	100 days
Speech Therapy (Outpatient) (ST)	$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Transplants	100% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility		
Facility Visit Charge	$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible
Wig (see Eligible Medical Expenses)	100% after Deductible	50% after Deductible
Maximum Benefit	$500 per course of treatment	
All Other Eligible Medical Expenses	100% after Deductible	50% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: $750 PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket)	
Single	$8,150
Family	$16,300
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Formulary Drug	$30 Copay
Non-Formulary Drug	$50 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through the PrudentRx Copay Program	
Generic Drug	$15 Copay
Formulary Drug	$30 Copay
Non-Formulary Drug	$50 Copay
Enrolled and Available in the PrudentRx Copay Program	$0 Copay
Not Enrolled and Available in the PrudentRx Copay Program	30% Copay
NOTE: Specialty drugs MUST be obtained directly from the Specialty Pharmacy Program. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program.	
CVS Maintenance Choice Voluntary: 90-day supply	
Generic Drug	$30 Copay
Formulary Drug	$60 Copay
Non-Formulary Drug	$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply	
Generic Drug	$30 Copay
Formulary Drug	$60 Copay
Non-Formulary Drug	$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

CVS Maintenance Choice Voluntary
This Plan allows for purchase of a 30-day supply of maintenance drugs at any retail pharmacy. A 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy only or through the mail order program. For additional information, please contact the Prescription Drug Card Program Administrator.

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Advanced Control Specialty Formulary
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

PrudentRx Copay Program for Specialty Medications
Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Copay Program will assist individuals in obtaining copay assistance from drug manufacturers to reduce an individual's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible persons will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications, in that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take.

If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copays for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count towards your Out-of-Pocket Maximum. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.