

RX OPTION I

SCHEDULE OF COPAYMENTS & LIMITATIONS

PRESCRIPTION DRUG BENEFIT BETWEEN \$0 AND \$275 IN TOTAL DRUG COSTS	COST SHARING
---	--------------

Network Retail Pharmacy (30-day supply)	Generic Drugs	100% (DISCOUNT ONLY)
	Brand Preferred Drugs	100% (DISCOUNT ONLY)
	Brand Non-Preferred Drugs	100% (DISCOUNT ONLY)

Network Retail Pharmacy (up to 90-day supply)	Generic Drugs	100% (DISCOUNT ONLY)
	Brand Preferred Drugs	100% (DISCOUNT ONLY)
	Brand Non-Preferred Drugs	100% (DISCOUNT ONLY)

Network Mail Order Pharmacy Maintenance Medication (up to 90-day supply)	Generic Drugs	100% (DISCOUNT ONLY)
	Brand Preferred Drugs	100% (DISCOUNT ONLY)
	Brand Non-Preferred Drugs	100% (DISCOUNT ONLY)

PRESCRIPTION DRUG BENEFIT BETWEEN \$276 and \$2,510 IN TOTAL DRUG COSTS (paid by member and plan)	COST SHARING
--	--------------

Network Retail Pharmacy (30-day supply)	Generic Drugs	25% Coinsurance
	Brand Preferred Drugs	25% Coinsurance
	Brand Non-Preferred Drugs	25% Coinsurance

Network Retail Pharmacy (up to 90-day supply)	Generic Drugs	25% Coinsurance
	Brand Preferred Drugs	25% Coinsurance
	Brand Non-Preferred Drugs	25% Coinsurance

Network Mail Order Pharmacy Maintenance Medication (up to 90-day supply)	Generic Drugs	25% Coinsurance
	Brand Preferred Drugs	25% Coinsurance
	Brand Non-Preferred Drugs	25% Coinsurance

PRESCRIPTION DRUG BENEFIT BETWEEN \$2,510 (paid by member and plan) AND \$4,050 (paid by member)	COST SHARING
---	--------------

Network Retail Pharmacy (30-day supply)	Generic Drugs	100% (DISCOUNT ONLY)
	Brand Preferred Drugs	100% (DISCOUNT ONLY)
	Brand Non-Preferred Drugs	100% (DISCOUNT ONLY)

Network Retail Pharmacy (up to 90-day supply)	Generic Drugs	100% (DISCOUNT ONLY)
	Brand Preferred Drugs	100% (DISCOUNT ONLY)
	Brand Non-Preferred Drugs	100% (DISCOUNT ONLY)

Network Mail Order Pharmacy Maintenance Medication (up to 90-day supply)	Generic Drugs	100% (DISCOUNT ONLY)
	Brand Preferred Drugs	100% (DISCOUNT ONLY)
	Brand Non-Preferred Drugs	100% (DISCOUNT ONLY)

PRESCRIPTION DRUG BENEFIT \$4,050 (paid by member) AND THEREAFTER	COST SHARING	
--	---------------------	--

Network Retail Pharmacy (30-day supply)	Generic Drugs Brand Preferred Drugs Brand Non-Preferred Drugs	\$2.25 for Generic or a Preferred Brand drug that is a multi-source drug and \$5.60 for all other drugs, or 5% coinsurance
---	---	--

Network Retail Pharmacy (up to 90-day supply)	Generic Drugs Brand Preferred Drugs Brand Non-Preferred Drugs	\$2.25 for Generic or a Preferred Brand drug that is a multi-source drug and \$5.60 for all other drugs, or 5% coinsurance
---	---	--

Network Mail Order Pharmacy Maintenance Medication (up to 90-day supply)	Generic Drugs Brand Preferred Drugs Brand Non-Preferred Drugs	\$2.25 for Generic or a Preferred Brand drug that is a multi-source drug and \$5.60 for all other drugs, or 5% coinsurance
--	---	--

Primary Care & Specialist Physician:	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket In Network Coinsurance Maximum	\$3,500	NA
Office Visit to Primary Care Physician (PCP)	\$10 copayment	30% after deductible is met
Home Visit by (PCP)	\$10 copayment	30% after deductible is met
After Hours Visit to (PCP)	\$10 copayment	30% after deductible is met
Office Visit to Specialist	\$20 copayment	30% after deductible is met
Emergency & Urgent Care:		
¹ Visit to Emergency Room	10% coinsurance	10% coinsurance
Urgently Needed Care	\$10 - \$20 copayment	\$10 - \$20 copayment
Ambulance	10% coinsurance	30% after deductible is met
Outpatient:		
Outpatient Rehabilitation Service Visit	\$20 copayment	30% after deductible is met
Outpatient Mental Health Visit	\$20 copayment	30% after deductible is met
Outpatient Substance Abuse Visit	\$20 copayment	30% after deductible is met
² Outpatient Facility Surgery	10% coinsurance	30% after deductible is met
Home Health Care	Covered in Full	30% after deductible is met
Lab (Outpatient)	10% coinsurance	30% after deductible is met
**X-Ray (Outpatient)	10% coinsurance	30% after deductible is met
Radiation Therapy	10% coinsurance	30% after deductible is met
Durable Medical Equipment	20% coinsurance	30% after deductible is met
Prosthetics	Covered in Full	30% after deductible is met
Diabetic Monitoring and Supplies	Covered in Full	30% after deductible is met
Dialysis	Covered in Full	30% after deductible is met
³ Certain Covered Injectables	\$50 copayment	30% after deductible is met
Chiropractic Services	\$20 copayment	30% after deductible is met
Non-Routine Podiatry	\$20 copayment	30% after deductible is met
Non-Routine Hearing Exam	\$20 copayment	30% after deductible is met
Non-Routine Vision Exam	\$20 copayment	30% after deductible is met
***Non-Routine Dental Services	10% coinsurance	30% after deductible is met
Preventive Care, Diagnostic, & Screening Tests:		
Prostate Cancer Screening Exam	Covered in Full	30% after deductible is met
Routine Physical Exams	Covered in Full	30% after deductible is met
Bone Mass Measurement	Covered in Full	30% after deductible is met
*Colorectal Screenings	Covered in Full	30% after deductible is met
Mammography	Covered in Full	30% after deductible is met
Pap Tests	Covered in Full	30% after deductible is met
Pelvic Exams	\$20 copayment	30% after deductible is met
Immunizations	Covered in Full	30% after deductible is met

⁴ Inpatient Hospital	Tier 1: \$100/day, \$500/stay Tier 2: \$200/day, \$1,000/stay unlimited days each benefit period	30% after deductible is met
Skilled Nursing Facility Services	\$25/day, 100 days per Medicare benefit period	30% after deductible is met
Mental Health Care		
Inpatient Mental Health Facility Days	\$100/day, \$500/stay 190 day Lifetime Benefit Maximum* in a Medicare approved Mental Health Facility	30% after deductible is met
⁴ Inpatient Acute Care Hospital Days	Tier 1: \$100/day, \$500/stay Tier 2: \$200/day, \$1,000/stay unlimited days each benefit period	30% after deductible is met
Substance Abuse Treatment/Detoxification		
Inpatient Substance Abuse Facility Days	\$100/day, \$500/stay 190 day Lifetime Benefit Maximum* in a Medicare approved Substance Abuse Facility	30% after deductible is met
Inpatient Non-Hospital Substance Abuse Days	90 day Lifetime Benefit Maximum for care provided in a Medicare approved Substance Abuse Treatment Facility	30% after deductible is met
⁴ Inpatient Acute Care Hospital Days	Tier 1: \$100/day, \$500/stay Tier 2: \$200/day, \$1,000/stay unlimited days each benefit period	30% after deductible is met
Hospice	Covered in Full at Medicare certified hospice	You must receive care from a Medicare certified Hospice
Medical Nutrition Therapy	Covered in Full	30% after deductible is met, requires prior authorization (approval in advance)
Blood	Covered in Full	30% after deductible is met, requires prior authorization (approval in advance)

¹ This Cost sharing will not be waived if the Member is admitted to the Hospital. Urgent and Emergency care received outside the U.S. (except under limited circumstances) are subject to out-of-network deductible and coinsurance. * 190 day Lifetime Maximum includes Mental Health and Substance Abuse Treatment received in a Medicare Approved Mental Health Facility. The Mental Health and Substance Abuse annual maximum is combined with Inpatient Hospital Maximum. ² Outpatient Facility Surgery: Per service when performed in an outpatient facility (Outpatient Department of Hospital, Short Procedure Unit, or Ambulatory Surgical Center). *If a colonoscopy is performed in an outpatient hospital setting, the outpatient hospital facility cost sharing applies. **Covered in full if performed in Emergency Room of Physician Office Setting. *** If services are performed in an outpatient hospital setting, the outpatient hospital facility cost sharing applies. If services are performed in an inpatient acute care facility, the inpatient hospital cost sharing applies.

³ There will be a \$50 copayment for the following covered Injectable drugs: Lupron, Zoladex, Trelstar.

⁴ Please note that if you are admitted to a Tier I or Tier II hospital due to an emergency, you are responsible for the applicable cost sharing level of that hospital.