SCHEDULE OF BENEFITS – PLAN B

Effective September 1, 2015

All benefits, unless otherwise specified, are based on Usual, Customary and Reasonable (UCR) charges, or the network contracted amounts, and are subject to the deductibles, benefit percentages and maximum amounts shown below. Members will use the CMR/Coventry network for services in Illinois or Missouri. Members will use the Aetna Choice POS II network for all services outside of Illinois or Missouri. A current list of Network Providers is available through the Trust website at www.egtrust.org. Please read the more detailed description of benefits, the description of covered expenses, and the Plan limitations and exclusions provided in your Plan booklet. If you have questions or need assistance in locating network providers, please call **Egyptian Area Schools Care Coordinators by Quantum Health at (855) 452-9997.**

Benefit Maximums		
Lifetime Maximum Benefits	Inpatient Mental/Nervous Treatment and Alcohol and Substance Abuse - 50 days Assisted Reproduction Techniques - $20,000	
Calendar Year Maximum Benefits	Outpatient Mental/Nervous Treatment and Alcohol and Substance Abuse - 52 visits Skeletal Adjustment - $750	
Deductible and Out-of-Pocket Maximum	**Network**	**Non-Network**
Calendar Year Deductible • Individual • Family	 $500/$600* $1,500/$1,800*	 $1,200 $3,600
Calendar Year Out-of-Pocket** • Individual • Family	 $1,200/$1,300* $3,600/$3,900*	 $4,100 $12,300
*The lower individual and family deductible and out of pocket amounts apply only if the member completes the wellness requirements. Network and Non-Network deductible and out-of-pocket amounts will accumulate separately.		
Affordable Care Act (ACA) Cost Share Maximum*** • Individual • Family	 $6,600 $13,200	 N/A N/A

**** The following expenses do not apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum**:

- Coinsurance for all mental/nervous, alcohol and/or substance abuse treatment charges;
- Charges for transplants outside the network;
- Charges for surgical procedures for morbid obesity outside the network;
- All copayment amounts;
- Spinal adjustment charges;
- Penalties for failure to pre-certify when required by the Plan;
- Any ineligible expenses;
- Any expenses in excess of the Lifetime or Calendar Year Maximums.

*****The following expenses will apply towards the ACA Cost Share Maximum:**

- Deductible and coinsurance that applies to the Out-of-Pocket Maximum;
- Coinsurance for all mental/nervous, alcohol and/or substance abuse treatment charges;
- All medical and prescription drug copayment amounts;
- Out of Network Emergency Room Services.

Description of Service	Network	Non-Network
A Copayment applies for each Inpatient Hospital Admission and Outpatient Surgical Procedure performed at an Outpatient Hospital Facility or Ambulatory Surgical Facility. (maximum of 3 such Copayments per person per calendar year) ***All charges are subject to the Calendar Year Deductible unless otherwise noted.***		
Inpatient Hospital Services for treatment of illness or injury (including Mental/Nervous, Alcohol and/or Substance Abuse)	$250 then 85%	$550 then 65%
Outpatient Surgery at a Hospital or Ambulatory Surgical Facility (except Emergency Room treatment)	$250 then 85%	$550 then 65%
Emergency Room Treatment (hospital and emergency room physician fee only). This does not include ambulance transportation.	$300 then 85%, no deductible	$300 then 85%, no deductible
Emergency Room Treatment - Out of Network treatment will be subject to the Network Out-of-Pocket Maximum.		
Urgent Care Center/Facility	$40 then 90%, no deductible	$40 then 90%, no deductible
Medically Necessary Ambulance Transportation	80%	80%
Medically Necessary Ambulance Transportation - Out of Network Medically Necessary Ambulance Expenses will be subject to the Network Out-of-Pocket Maximum.		
Pre-admission Testing	100%, no deductible	100%, no deductible
Physician's Inpatient Visits (includes Medical, Surgical, Mental/Nervous, Alcohol and/or Substance Abuse visits)	85%	65%
Second Surgical Opinion	100%, no deductible	100%, no deductible
Diagnostic Laboratory Expenses (other than Independent Lab)	85%	65%
Diagnostic Laboratory Expenses (Independent Lab)	100%, no deductible	100%, no deductible
Diagnostic Laboratory Expenses – When a covered member uses the services of a Network Independent Lab provider, there will be no out-of-pocket expense to the member and covered services will be covered at 100%.		
Diagnostic X-ray Expenses	85%	65%
Organ and Tissue Transplants	90%, no deductible	50% up to $50,000
Surgical Treatment of Morbid Obesity	85%	50% up to $50,000

Description of Service	Network	Non-Network
All charges are subject to the Calendar Year Deductible unless otherwise noted.		
Primary Doctor Office Visit or Retail Clinic Visit (Includes general or family practice, internists, pediatricians and OB/GYN physicians)	$25 then 100%, no deductible	65%
Specialist Physician Office Visit (With a referral by your Primary Doctor)	$30 then 100%, no deductible	65%
Specialist Physician Office Visit (Without a referral by your Primary Doctor)	$40 then 100% no deductible	65%
Adjunctive Services in Physician's Office, Retail Clinic or Urgent Care Center/Facility	85%	65%
Physician's Outpatient Mental/Nervous, Alcohol and/or Substance Abuse Visits	85%	65%
Skeletal Adjustment	50%	50%
Durable Medical Equipment	85%	65%
Physical, Speech or Occupational Therapy	85%	65%
Home Health Care Home Infusion Skilled Nursing Facility Hospice Care	85%	65%
Covered Prescription Drugs not covered under the Drug Card Benefit	80%	80%
All Other Covered Expenses	85%	65%

PRESCRIPTION DRUG CARD BENEFIT

You have the option to fill the first two months of a newly prescribed maintenance medication at any local retail pharmacy for the normal 30 day co-pay. After the first two fills of a maintenance medication, each fill afterward will be required to be a 90 day fill at either a participating 90 day retail pharmacy or through Home Delivery. You can buy up to a 30 day supply of any covered medication that is not a maintenance medication and is not a specialty medication at any retail pharmacy.

You are required to purchase specialty drugs through CVS Caremark Specialty Pharmacy and are limited to a 30 day supply. Specialty drugs are very high cost biologic and injectable drugs that are not typically stocked by retail pharmacies. **If a member tries to fill a specialty script at retail, the pharmacy will notify the member that the drug must be ordered from** CVS Caremark. You may begin using CVS Caremark for those specialty medications at any time by calling **(800) 237-2767.**

Prescription Drug Copayments	Retail 30 day supply	Retail 90 day supply Maintenance drugs after first 2 fills	Home Delivery up to 90 day supply
Generic	$12	$36	$30
Preferred Brand	$25	$85	$55
Non-Preferred	$40	$130	$100
Injectables	Copay plus 3%	Copay plus 3%	Copay plus 3%
All specialty drugs (oral and injectable) will have a maximum copay of $150 per month.			

WELLNESS BENEFIT

The Plan covers certain routine health care services and recommended preventive services based on guidelines published by the USPSTF, CDC, and HRS (the Guidelines), as described under Wellness / Preventive Services in the Covered Major Medical Expenses section of the Plan Document and Summary Plan Description and as outlined on the following page.

Description of Wellness Service	Network	Non-Network
Charges are <u>not</u> subject to the Calendar Year Deductible except as noted.		
Wellness Office Visit for Children (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	65%, after deductible
Wellness Office Visit for Adolescents and Adults (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	65%, after deductible
Childhood Immunizations and Vaccinations per Guidelines	100%	100%
Adult Immunizations and Vaccinations per Guidelines; Includes HPV vaccine	100%	65%, after deductible
Flu vaccine	100%	100% up to $40 maximum
Pneumonia vaccine per Guidelines	100%	100% up to $85 maximum
Zoster (Zostavax) for Shingles per Guidelines	100%	100% up to $200 maximum
Tetanus, Diptheria Toxoids per Guidelines	100%	100% up to $40 maximum
Hepatitis A and B per Guidelines	100%	100% up to $100 maximum
Combined Tetanus, Diptheria and Pertussis (TDAP) per Guidelines	100%	100% up to $55 maximum
Mammogram (limited to 1 per calendar year)	100%	100%
Routine Pap Smear (limited to 1 test per calendar year)	100%	100%
Routine PSA Test (limited to 1 test per calendar year)	100%	100%
Routine Laboratory, X-ray and Screening Tests recommended by Guidelines: No dollar limit.	100%	65%, after deductible
All other routine tests limited to $100 calendar year maximum benefit.		
Routine Annual Biometric Screening: Includes height, weight, blood pressure, glucose, HDL, LDL, total cholesterol, triglycerides	100%	100% up to $75 maximum
Routine Screening for Colorectal Cancer using fecal occult blood testing, sigmoidoscopy or colonoscopy (age 50 and over). Frequency as provided by Guidelines.	100%	65%, after deductible
Other recommended preventive services (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	65%, after deductible

Recommended Preventive Services

The following is a **partial list** of services that are covered by the Plan when specifically listed under the Wellness Benefit or when recommended for individuals of the patient's age, gender or health risk factors, in accordance with Guidelines published by the USPSTF, CDC or HRSA. An up-to-date list of the current Guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/

For Children:

- Well child exams
- Standard routine immunizations recommended by the Guidelines
- Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia
- Gonorrhea preventive medication for eyes in at risk newborns
- Standard metabolic screening panel for inherited enzyme deficiency diseases
- Screening and counseling for obesity
- Evaluation for fluoride treatment and fluoride supplements
- Behavioral assessments
- Screening for autism (at 18 and 24 months)
- Vision screening
- Oral health assessment
- Developmental screening, autism screening and behavioral assessment
- Screening for lead and tuberculosis

For Women:

- Annual physical exam
- Annual screening mammogram
- Annual pap smears, screening for cervical cancer, HPV testing
- Evaluation, counseling and genetic testing for BRCA breast cancer gene and/or for chemoprevention for women at high risk for breast cancer due to family history or other factors
- Screening pregnant women for anemia, gestational diabetes, iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility
- Screening for gonorrhea, chlamydia, syphilis
- Counseling and equipment to promote and aid with breast feeding
- Folic acid supplements for pregnant women
- Screening for domestic and interpersonal violence
- Osteoporosis screening (age 60 or older)
- FDA approved contraceptive methods, sterilization procedures and counseling

A detailed listing of women's preventive services can be found at: http://www.hrsa.gov/womensguidelines/

For Men:

- Annual physical exam
- Annual PSA test/screening for prostate cancer
- Screening for abdominal aortic aneurysm (ages 65 – 75 with history of smoking)

For Adolescents and Adults at Appropriate Ages or With Risk Factors:

- Screening for elevated cholesterol and lipids, high blood pressure, diabetes
- Screening and counseling for certain sexually transmitted diseases and HIV
- Screening and counseling for hepatitis B and C
- Screening and counseling for alcohol abuse in a primary care setting
- Screening, counseling and interventions for tobacco use
- Screening and counseling for obesity, diet and nutrition
- Screening for depression in a primary care setting
- Screening for colorectal cancer (ages 50 – 75)
- Screening for lung cancer (ages 55 – 80 with history of smoking)
- Standard routine immunizations recommended by the Guidelines
- Aspirin to prevent cardiovascular disease (women ages 55 – 79; men ages 45 – 79)

In some cases the Guidelines specify how often the Plan must cover a service as a recommended preventive service when provided by a Network provider. In other cases, the Plan may impose reasonable frequency limits or may use reasonable medical management techniques to ensure that care is provided in an appropriate setting.

Questions about whether a service will be covered by the Plan as a recommended preventive service for an individual should be directed to **Egyptian Area Schools Care Coordinators by Quantum Health at (855) 452-9997.**