MEDICAL SCHEDULE OF BENEFITS: MPPOA-20-1

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE - EMBEDDED (combined with Prescription Drug Card)		
Single	$250	$1,000
Family	$500	$2,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM - EMBEDDED (includes Deductible and Coinsurance – combined with Prescription Drug Card)		
Single	$2,000	$6,000
Family	$4,000	$12,000
MEDICAL BENEFITS		
Allergy Injections	**100%; Deductible waived**	50% after Deductible
Ambulance Services	80% after Deductible	**Paid at Participating Provider level of benefits**
Ambulatory Surgical Center	80% after Deductible	50% after Deductible
Anesthesia (Including Administration) (Inpatient and Outpatient)	80% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation		
Under age 19	**100%; Deductible waived**	50% after Deductible
Age 19 and over	**$20 Copay, then 100%; Deductible waived**	50% after Deductible
Calendar Year Maximum Benefit	**26 visits**	
Diabetic Education	80% after Deductible	50% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	**100%; Deductible waived**	50% after Deductible
MRI, MTA, CAT and PET Scans	80% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	50% after Deductible
Emergency Services/Emergency Room Services	**$150 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	80% after Deductible	50% after Deductible
Maximum Benefit	**1 pair every 24 months**	
Hearing Aids	80% after Deductible	50% after Deductible
Maximum Benefit	**For Covered Persons under age 19:** limited to a single	

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
	purchase (including repair/replacement) per hearing impaired ear every 3 Calendar Years. **For Covered Persons age 19 and older:** limited to $2,500 per Calendar Year and single purchase (including repair/replacement) per hearing impaired ear every 3 Calendar Years.	
Home Health Care	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	**60 visits**	
Hospice Care	80% after Deductible	50% after Deductible
Hospice Bereavement Counseling (within 6 months of Covered Person's death)	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	**5 visits per family**	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% 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	80% after Deductible	50% after Deductible
Outpatient	80% 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.		
Infertility Treatment	**Same as any other Illness**	**Same as any other Illness**
Lifetime Maximum Benefit	**$35,000**	
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Maternity (Professional Fees)*		
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	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	50% after Deductible
Outpatient Under age 19 Age 19 and over	**100%; Deductible waived** **$20 Copay, then 100%; Deductible waived**	50% after Deductible 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.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Outpatient Therapies (e.g., hearing, physical, speech, occupational)	80% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	**60 visits**	
Pediatric Dental and Vision Services **(**for Covered Persons through the end of the month in which they turn age 19 only)		
Pediatric Dental	**100%; Deductible waived**	**100%; Deductible waived**
Calendar Year Maximum Benefit	Refer to the Pediatric Dental section under Eligible Medical Expenses for specific limits related to this benefit.	
Pediatric Vision		
Routine Vision Exam	**100%; Deductible waived**	**100%; Deductible waived**
Lenses	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	**1 routine vision exam and 1 set of lenses**	
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits:		
Primary Care Physician – under age 19	**100%; Deductible waived**	50% after Deductible
Primary Care Physician – age 19 and over	**$20 Copay, then 100%; Deductible waived**	50%; after Deductible
Specialist	**$50 Copay, then 100%; Deductible waived**	50% after Deductible
Lab and X-ray Services Rendered During an Office Visit	**100%; Deductible waived**	50% after Deductible
All Other Services and Supplies Rendered During an Office Visit	80% after Deductible	50% after Deductible
Physician Office Surgery	80% after Deductible	50% after Deductible
Preventive Services and Routine Care (includes the office visit and any other eligible item or service received at the same time as the preventive service or routine care, whether billed at the same time or separately)	**100%; Deductible waived**	50% after Deductible
Flu Vaccine (regardless of where performed)	**100%; Deductible waived**	**100%; Deductible waived**
Shingles Vaccine (regardless of where performed)	**100%; Deductible waived**	**100%; Deductible waived**
Breast Pumps and Supplies	**100%; Deductible waived**	**100%; Deductible waived**
NOTE: Preventive prenatal and breastfeeding support are paid under the Maternity Benefit. Please see Maternity listed above for additional details.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Second Surgical Opinion	**100%; Deductible waived**	**100%; Deductible waived**
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	**60 days**	
Temporomandibular Joint Dysfunction (TMJ)	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	**$1,000**	
Transplants	80% after Deductible (Aetna IOE Program)* **Not covered (All Other Network Providers)**	**Not Covered**
* 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	**$70 Copay, then 100%; Deductible waived**	50% after Deductible
Lab and X-ray Services Rendered During a Visit	**100%; Deductible waived**	50% after Deductible
All Other Services and Supplies Rendered During a Visit	80% after Deductible	50% after Deductible
Wig (see Eligible Medical Expenses)	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	**1 wig**	
All Other Eligible Medical Expenses	80% after Deductible	50% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: R-005 PPO COPAY PLAN

BENEFIT DESCRIPTION	BENEFIT
Retail Pharmacy: 30-day supply	
Generic Drug	**$5** Copay, then 100%
Formulary Drug	**$45** Copay, then 100%
Non-Formulary Drug	**$70** Copay, then 100%
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (Plan pays 100%)
CVS Retail Pharmacy Only: 90-day supply	
Generic Drug	**$12.50** Copay, then 100%
Formulary Drug	**$112.50** Copay, then 100%
Non-Formulary Drug	**$175** Copay, then 100%
Diabetic Medications and Supplies	**$0** Copay (Plan pays 100%)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	**$0** Copay (Plan pays 100%)
Mandatory Specialty Pharmacy: 30-Day Supply	
Specialty Drug	**20%** Copay
NOTE: This Plan participates in the Specialty Split-Fill Program, which allows you to fill 2 15-day cycles of a limited list of specialty drugs in the first month. Your Copay will be prorated to help ensure you can tolerate the medication and handle any potential side effects before trying a full 30-day supply.	
NOTE: Specialty drugs MUST be obtained directly from the Specialty Pharmacy. Specialty drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Mail Order Pharmacy: 90-day supply	
Generic Drug	**$12.50** Copay, then 100%
Formulary Drug	**$112.50** Copay, then 100%
Non-Formulary Drug	**$175** Copay, then 100%
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	**$0** Copay (Plan pays 100%)