SCHEDULE OF BENEFITS

Employer Contract Number: 70-53995-00 through 06 and 09 through 44
Employer: National Wild Turkey Federation
Buy Up Plan
Plan of Benefits Effective Date: January 1, 2018

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider. Please call 800-810-BLUE (2583) or access our website at www.SouthCarolinaBlues.com to find out if your Provider is a Participating Provider.

GENERAL PROVISIONS

When a Benefit is listed below and has a dollar or percentage amount associated with it, the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the location of the service (e.g., inpatient, outpatient, office). When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.

Probationary Period:	Coverage for new Employees hired following the Effective Date of this Plan of Benefits will commence on the first monthly Effective Date following date of employment.
In addition to meeting the requirements contained in this Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	A Child under the age of twenty-six (26).
Actively at Work: **Minimum hours per week:** **Minimum weeks per year:**	 At least thirty (30) hours per week. At least forty eight (48) weeks per year.

Benefit Year Deductible:	$2,000 per family with no one Member meeting more than $1,000 for Participating Providers. $4,000 per family with no one Member meeting more than $2,000 for Non-Participating Providers. Employees and/or their spouses may individually earn two credits toward the Benefit Year Deductible for services rendered at a Participating Provider. Each credit is valued at $125. Any earned credits will be applied to the current Benefit Year only and will not be carried over for use in another Benefit Year. For complete details see your Employer or call Customer Service at the number listed in the front of this booklet. Covered Expenses for services rendered by Participating or Non-Participating Providers will be applied only to the Participating Provider Benefit Year Deductible or the Non-Participating Provider Benefit Year Deductible, respectively.
Out-of-Pocket Maximums for Participating Providers:	**Standard Out-of-Pocket Maximums:** $5,000 per family with no one Member meeting more than $2,500. Benefit Year Deductibles and Coinsurance contribute to the Standard Out-of-Pocket Maximum, with the exception of chiropractic services. Allowable Charges for Coinsurance are paid at 100% after the Standard Out-of-Pocket Maximum is met, except as specified above. The Member will still be responsible for any applicable Copayments until the Out-of-Pocket Maximum is met. **Out-of-Pocket Maximums:** $14,700 per family with no one Member meeting more than $7,350. All Benefit Year Deductibles and Coinsurance incurred, with the exception of chiropactic services, will contribute to the Out-of-Pocket Maximum. All Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance, Benefit Year Deductibles and Copayments for services rendered at a Participating Provider will apply to the Standard Out-of-Pocket Maximum or Out-of-Pocket Maximum as listed above and will not be applied to the Non-Participating Provider Out-of-Pocket Maximum.

Out-of-Pocket Maximums for Non-Participating Providers:	$23,200 per family with no one Member meeting more than $11,600. Coinsurance for chiropractic services and Copayments do not contribute to the Out-of-Pocket Maximum determination. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance and Benefit Year Deductibles for services rendered at a Non-Participating Provider will apply to the Non-Participating Provider Out-of-Pocket Maximum only and will not be applied to either the Standard Out-of-Pocket Maximum or Out-of-Pocket Maximum for Participating Providers.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid. The Copayment for each Admission is $250 for a Non-Participating Provider. This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 01/01. There are no annual or lifetime dollar limitations on essential health Benefits as defined by the Affordable Care Act (ACA).

PREAUTHORIZATION	
Inpatient	**All Admissions require Preauthorization** If Preauthorization is not obtained, room and board charges will be denied. Other services may also require preauthorization. All charges will be denied for human organ and tissue transplant services not performed at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing.
Outpatient	Preauthorization is required for the following outpatient Benefits: • Any surgical procedure that may be potentially cosmetic: i.e., blepharoplasty, reduction mammoplasty • Cancer chemotherapy • Hysterectomy • Investigational procedures • Septoplasty • Radiation therapy Benefits for outpatient services that require Preauthorization will be reduced by 50% of the Allowable Charge when Preauthorization is not obtained or approved by the Corporation.
Mental Health Services and Substance Use Disorder Services	Preauthorization is required for the following Mental Health Services and Substance Use Disorder Services: • Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder (Preauthorization requests and treatment plans must be submitted to CBA) • Facility-based inpatient services • Facility-based outpatient services (partial hospitalization, electroconvulsive therapy (ECT) and intensive outpatient programs) • Psychological testing • Repetitive transcranial magnetic stimulation (rTMS) Benefits for ABA related to Autism Spectrum Disorder will be denied when Preauthorization is not obtained or approved by the Corporation. If Preauthorization is not obtained or approved by the Corporation for facility-based inpatient services, charges for room and board will be denied. Benefits for psychological testing and rTMS performed in the office and for the facility-based outpatient services listed above will be reduced by 50% of the Allowable Charge when Preauthorization is not obtained or approved by the Corporation.

Other Services	Preauthorization is required for the following services:
	
	• Ambulance services (when reasonable under the circumstances)
	• Cleft lip and palate
	• Dental care for accidental injury (Preauthorization is required for the treatment plan and subsequent visits)
	• Durable Medical Equipment if purchase or rental is $500 or more
	• Home Health Care
	• Hospice Care
	• Orthopedic devices
	• Orthotic devices
	• Oxygen
	• Radiology Management
	  • CAT scans
	  • MRI
	  • MRA
	  • Musculoskeletal care
	  • PET scans
	  • Radiation treatment plans related to oncology
	
	Benefits for durable medical equipment, Home Health Care, Hospice Care, radiation treatment plans related to oncology, musculoskeletal care, MRIs, MRAs, CAT scans and PET scans performed in an outpatient facility will be denied when Preauthorization is not obtained or approved by the Corporation. Preauthorization may be required for outpatient rehabilitation services.

Pharmacy	Please refer to the Corporation's website for a complete list of Prescription Drugs and Specialty Drugs that require Preauthorization.

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital charges for room and board related to Admissions	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 60% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services, including labor and delivery rooms, drugs, medicine, lab and X-ray services)	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 60% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge
Inpatient physical rehabilitation services when Preauthorized by the Corporation and performed by a Provider designated by the Corporation	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 60% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions, limited to sixty (60) days per Benefit Year	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 60% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis, including: lab, X-ray and other diagnostic services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
True emergency room visits	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Non-true emergency room visits	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other covered outpatient Benefits	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

PROVIDER SERVICES OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Provider Services in a Hospital	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgical Services, when rendered in a Hospital, Provider's office or Ambulatory Surgical Center	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Services in the Provider's office, including contraceptives and birth control devices (other than Surgical Services, maternity care, physical therapy, dialysis treatment and Second Surgical Opinion) This Benefit does not include preventive Benefits offered under the ACA. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the ACA.	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $50 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Provider Services in the Member's home	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Second Surgical Opinion	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Provider Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Inpatient Hospital charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 60% of the Allowable Charge The Member must pay the balance of the Provider's charge
Residential Treatment Center Admissions for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 60% of the Allowable Charge after the Copayment The Member must pay the balance of the Provider's charge
Outpatient Hospital or clinic charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 60% of the Allowable Charge The Member must pay the balance of the Provider's charge
Outpatient Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Office Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital emergency room charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OTHER SERVICES		
	Participating Provider	**Non-Participating Provider**
Ambulance service (including air ambulance)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Durable Medical Equipment, Prosthetics and Orthopedic Devices	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Medical Supplies	Covered	Covered
Home Health Care, limited to sixty (60) visits per Benefit Year	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospice Care, limited to six (6) months per episode	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Colorectal cancer screenings limited to: • One (1) fecal occult blood testing of three (3) consecutive stool samples per Benefit Year • One (1) flexible sigmoidoscopy every five (5) years • One (1) double contrast barium enema every five (5) years • One (1) colonoscopy every ten (10) years	Covered	Covered
ABA related to Autism Spectrum Disorder	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Provider charges for rehabilitation related to physical therapy and occupational therapy (Limited to a combined thirty (30) visits per Member per Benefit Year. Please see the ''Outpatient Rehabilitation'' section in Article III of the Plan of Benefits for limitations)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider charges for habilitation related to physical therapy and occupational therapy (Limited to a combined thirty (30) visits per Member per Benefit Year. Please see the ''Outpatient Rehabilitation'' section in Article III of the Plan of Benefits for limitations)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Rehabilitation related to speech therapy (Limited to twenty (20) visits per Member per Benefit Year. Please see the ''Outpatient Rehabilitation'' section in Article III of the Plan of Benefits for limitations)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation related to speech therapy (Limited to twenty (20) visits per Member per Benefit Year. Please see the ''Outpatient Rehabilitation'' section in Article III of the Plan of Benefits for limitations)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Human organ and tissue transplant services Human organ and tissue transplant services are only covered if provided at a Blue Distinction® Center of Excellence or a transplant center approved by the Corporation in writing Provider charges are subject to the Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	Non-Covered
Allergy injections	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Chiropractic services, including spinal manipulation/subluxation, related X-rays, and modalities , limited to a $250 maximum payment per Member per Benefit Year	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Oxygen	Covered	Covered
Supplemental accident Benefits (the first $200 incurred per Benefit Year is payable at 100% and is not subject to the Benefit Year Deductible)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Sustained Health services related to an annual physical exam (limited to $450 per Member per Benefit Year) This Benefit does not include preventive Benefits offered under the ACA. Payment will be made for the ACA preventive Benefits prior to Sustained Health services. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the ACA.	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment	Non-Covered

PREVENTIVE BENEFITS The Benefit Year Deductible does not apply to these Benefits		
	Participating Provider	**Non-Participating Provider**
Preventive Benefits under the ACA (Refer to www.healthcare.gov for guidelines)	Covered	Non-Covered
Pap smear screenings (the report and interpretation only, limited to one (1) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Prostate screenings (limited to one (1) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Gynecological exam (limited to two (2) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
In South Carolina:		
	SC Mammography Network	**All Other Providers**
Mammography screenings (limited to one (1) per Benefit Year for any female Member age forty (40) or older)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Outside South Carolina:		
	Out-of-State Participating Providers	**All Other Providers**
Mammography screenings (limited to one (1) per Benefit Year for any female Member age forty (40) or older)	The Corporation pays 100% of the Allowable Charge	Non-Covered

PRESCRIPTION DRUG BENEFIT			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	The Member pays a $25 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $15 Prescription Drug Copayment for each monthly prescription or refill, up to a 90 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $15 Prescription Drug Copayment per Member for each monthly prescription or refill, up to a 90 day supply
Preferred Brand Drug	The Member pays a $90 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $40 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $40 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply
Non-Preferred Brand Drug	The Member pays a $175 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $70 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $70 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply

Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
*Contraceptives: oral contraceptives, cervical cap, diaphragms, emergency contraception, female condom, implantable rod, intrauterine device (IUD), patch, shot/injection, spermicide, sponge, vaginal contraceptive ring and approved sterilization procedures for women A complete list of specific Prescription Drugs or supplies covered at 100% is available at www.SouthCarolinaBlues.com	Prescription Drugs will be covered at 100%, up to a 90 day supply	Prescription Drugs will be covered at 100%, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100%, up to a 31 day supply
**All other contraceptives (Prescription Drugs)	Covered	Covered	Covered
Sexual dysfunction Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Tobacco cessation Prescription Drugs	Covered	Covered	Covered
Obesity/weight control Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Infertility Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Cosmetic Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Prescription Drug deductible	$0 (No Prescription Drug deductible)	$0 (No Prescription Drug deductible)	$0 (No Prescription Drug deductible)
Prescription Drug out-of-pocket	$0 (No Prescription Drug out-of-pocket)	$0 (No Prescription Drug out-of-pocket)	$0 (No Prescription Drug out-of-pocket)
Maximum Prescription Drug Benefit	$0 (No maximum Prescription Drug Benefit)	$0 (No maximum Prescription Drug Benefit)	$0 (No maximum Prescription Drug Benefit)

Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Diabetic syringes and supplies***	Covered	Covered	Covered
Syringes and related supplies for conditions, such as cancer or burns, test tape, surgical trays and renal dialysis supplies	Non-Covered	Non-Covered	Non-Covered
*Contraceptives listed above are covered under the participating medical Benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary. **All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand payment levels. ***A separate Prescription Drug Copayment applies for each supply purchase.			

SPECIALTY DRUG BENEFIT		
	Participating Pharmacy	**All Other Pharmacies**
Specialty Drugs	$125 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply	Non-Covered