

MEDICAL HIGH DEDUCTIBLE SCHEDULE OF BENEFITS

BENEFIT	PARTICIPANT RESPONSIBILITY
PRESCRIPTION DRUGS Note: For Brand Name drugs with generic equivalents, should patient request the Brand Name Drug, the Participant will pay the Brand Name Drug Copay plus the difference in price between the Brand Name and the Generic equivalent.	See Section D for a complete description of Prescription Drug Covered Services
Retail Prescription Drugs (30 day supply) Generic Drug Formulary Brand Name Drug Non Formulary Brand Name Drug	20% Copay 30% Copay 40% Copay
Mail Order Prescription Drugs (90 day supply) Generic Drug Formulary Brand Name Drug Non Formulary Brand Name Drug	15% Copay 25% Copay 35% Copay

BENEFIT	PARTICIPANT RESPONSIBILITY	
	PPO IN NETWORK	OUT OF NETWORK
For Covered Services by a Out of Network Provider, charges in excess of Reasonable and Customary are the Participant's responsibility		
CALENDAR YEAR DEDUCTIBLE		
Per Individual	\$2,000	\$4,000
Per Family	\$4,000	\$8,000
CALENDAR YEAR OUT OF POCKET MAXIMUM (Includes Deductible)		
Per Individual	\$5,000	\$10,000
Per Family	\$8,000	\$16,000
PHYSICIAN SERVICES		
Office Visits		
Primary Care	20% Coinsurance	40% Coinsurance
Specialists	20% Coinsurance	40% Coinsurance
Urgent Care	20% Coinsurance	40% Coinsurance
Office Laboratory/X-ray	20% Coinsurance	40% Coinsurance
Office Surgery	20% Coinsurance	40% Coinsurance
Hospital/Extended Care/Nursing Home Visits	20% Coinsurance	40% Coinsurance
Maternity Charges – (initial office visit)	20% Coinsurance	40% Coinsurance
Outpatient Surgery (Also see Hospital Services Outpatient Surgery Facility Copay)	20% Coinsurance	40% Coinsurance
Inpatient Surgery (Also see Hospital Services Per Admission Copay)	20% Coinsurance	40% Coinsurance
Second Surgical Opinion	20% Coinsurance	40% Coinsurance
Allergy Injections (If billed in conjunction with an office visit Copay only office visit Copay applies)	20% Coinsurance	40% Coinsurance
Allergy Serums and Testing	20% Coinsurance	40% Coinsurance
Injectable Medications (other than Allergy or Depo Provera) in the Physician's office	20% Coinsurance	40% Coinsurance

BENEFIT	PARTICIPANT RESPONSIBILITY	
	PPO IN NETWORK	OUT OF NETWORK
Depo-Provera Injections (If billed in conjunction with an office visit Copay only office visit Copay applies)	20% Coinsurance	40% Coinsurance
Chiropractic Care - Limited to \$200 per Calendar year for diagnostic lab or x-ray and an additional \$1,000 per Calendar Year for all other Covered Services. Benefits are further limited to \$35 payable per visit except for the initial office visit evaluation.		
Initial Office Visit Evaluation	20% Coinsurance	40% Coinsurance
Ongoing Treatment – per visit	20% Coinsurance	40% Coinsurance
ROUTINE & PREVENTIVE SERVICES	\$500 Calendar Year Maximum	
Including but not limited to exams, pap smears, mammograms, immunizations, and well child care. Expenses Incurred over the \$500 Calendar Year Maximum are the Participant's responsibility.		
Office Visits and Immunizations	\$20 Copay	40% Coinsurance
Laboratory/X-ray	\$0 Copay	40% Coinsurance
HOSPITAL SERVICES		
Per Admission (for other than Mental Health and Substance Abuse) at semi-private room rates	20% Coinsurance	40% Coinsurance
Pre-admission Testing	20% Coinsurance	40% Coinsurance
Outpatient Surgery Facility	20% Coinsurance	40% Coinsurance
Outpatient Laboratory/X-ray except for those listed below	20% Coinsurance	40% Coinsurance
Outpatient CT Scan, Magnetic Resonance Imaging (MRI) and/or Echo Cardiogram	20% Coinsurance	40% Coinsurance
Emergency Room Treatment (Copay waived if admitted)	20% Coinsurance	40% Coinsurance
Outpatient Dialysis Treatment	20% Coinsurance	40% Coinsurance
MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT		
In addition to the maximums outlined below, Mental Health/Substance Abuse treatment is further limited to 60 days per lifetime.		
Inpatient – Maximum of 30 days per Calendar Year	20% Coinsurance	40% Coinsurance
Outpatient – Maximum of 20 visits per Calendar Year	20% Coinsurance	40% Coinsurance
OTHER COVERED SERVICES		
Ambulance		
Ground Transportation	20% Coinsurance	
Air Ambulance when Medically Necessary	20% Coinsurance	
Chemotherapy and Radiation Services	20% Coinsurance	40% Coinsurance
Durable Medical Equipment/Prosthetic Devices	20% Coinsurance	40% Coinsurance
Home Health Care – Limited to 100 visits per Calendar Year	20% Coinsurance	40% Coinsurance
Hospice Care	20% Coinsurance	40% Coinsurance
Infertility Treatment	Not Covered	
Organ and Tissue Transplants	20% Coinsurance at Designated Transplant Facility	Not covered

BENEFIT	PARTICIPANT RESPONSIBILITY	
	PPO IN NETWORK	OUT OF NETWORK
Rehabilitation Services Home IV Therapy Physical, Speech, & Occupational Therapy – Limited to 60 visits for each therapy per Sickness or Injury	20% Coinsurance	Not Covered
Skilled Nursing Facility Services- Limited to 60 days per confinement	20% Coinsurance	40% Coinsurance
Smoking Cessation Treatment – Limited to 3 courses of treatment per lifetime	20% Coinsurance	40% Coinsurance
Sterilization	20% Coinsurance	40% Coinsurance
Temporomandibular Joint Dysfunction (TMJ) – Limited to \$1,000 per lifetime	20% Coinsurance	40% Coinsurance
Weight Loss Treatment – Limited to \$2,400 per Calendar Year and 3 courses of treatment per lifetime	20% Coinsurance	40% Coinsurance
Non Prior Authorization Penalty for certain services	\$250 per event	
All Other Covered Services	20% Coinsurance	40% Coinsurance
PLAN MAXIMUM(S) while covered under the Plan(s) of the Plan Sponsors		
Lifetime	\$1,000,000	
Chiropractic Care per Calendar Year	\$200 for diagnostic lab & x-ray, \$1,000 for all other Covered Services.	
Home Health Care per Calendar Year	100 visits	
Hospice Care per lifetime	\$10,000	
Mental Health/Substance Abuse per Calendar Year Inpatient Outpatient	30 visits 20 days	
Mental Health/Substance Abuse per lifetime Inpatient & Outpatient	60 days	
Skilled Nursing Facility per confinement	60 days per confinement	
Physical, Speech or Occupational Therapy per Sickness or Injury - for each therapy per Calendar Year	60 visits	
Temporomandibular Joint Dysfunction (TMJ) per lifetime	\$1,000	
Covered Services for the following benefits are excluded from the Out of Pocket Maximum: Mental Health Conditions and/or Substance Abuse treatment Copay's Chiropractic Care Non Prior Authorization Penalties Prescription Drug expenses		