

SECTION II

SCHEDULE OF BENEFITS

The following charts summarize benefit information. Please refer to specific benefit sections for more detailed explanations.

DESCRIPTION OF MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Lifetime Maximum	\$1,000,000	
Calendar Year Deductible		
• Individual	\$500	
• Family	\$1,500	
Calendar Year Out-of-Pocket Maximum (excluding Deductible and Copays)		
• Individual	\$1,250	\$2,000
• Family	\$3,750	\$6,000
Utilization Review Requirements All Inpatient Hospital confinements must be pre-certified prior to a scheduled admission or within 48 hours of an emergency admission. Pregnancy related admissions for delivery will not require certification unless the confinement exceeds 72 hours for a vaginal delivery or 120 hours for a cesarean section delivery. It is the Employee's responsibility to obtain pre-certification or charges will be reduced by a \$200 penalty. Penalty does not apply toward the Calendar Year Deductible or Out-of-Pocket Maximum.		
Hospital Services	90%	70%
• Inpatient (See Utilization Review Requirements)	after Deductible	after Deductible
• Outpatient		
Emergency Room Services		
• Medical Emergency (as defined by the Plan)	90% after Deductible	70% after Deductible
• Non-Medical Emergency	\$100 Copay then 90% after Deductible	\$100 Copay then 70% after Deductible
Alternate Treatment Facility	90% after Deductible	70% after Deductible
Hospital Pre-Admission Testing	90% after Deductible	70% after Deductible
Outpatient Surgical	90% after Deductible	70% after Deductible
Second Surgical Opinion Voluntary	90% after Deductible	70% after Deductible
Physician Office Visits	90% after Deductible	70% after Deductible
Other Physician Services		
• Hospital visits		
• Surgeon and assistant surgeon	90%	70%
• Anesthesiologist	after Deductible	after Deductible
• Radiologist and pathologist		
Note: Services of Non-Network radiologists, anesthesiologists and pathologists when rendered in a Network facility will be reimbursed at the Network level.		

DESCRIPTION OF MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<p>Wellness Care/Routine Care Routine preventive care includes, but is not limited to:</p> <ul style="list-style-type: none"> • Physical examination – including Diagnostic Charges • GYN exam • Pap Smear • Mammograms as follows: <ul style="list-style-type: none"> - Ages 30 through 39, one baseline - Ages 40 and over, one per year • Prostate screening • Bone Mineral Density (BMD) test • Screening Colonoscopy, once every five years beginning at age 50 	<p>\$15 Copay (per visit) then 100% no Deductible</p>	<p>\$30 Copay (per visit) then 100% no Deductible up to \$400 Calendar Year maximum then payable at 70% after Deductible</p>
<p>Well Child Care Routine immunizations up to age 12.</p>	<p>100% no Deductible</p>	<p>100% no Deductible</p>
<p>Mental/Nervous Disorders</p> <ul style="list-style-type: none"> • Inpatient treatment limited to 30 days per Calendar Year. <ul style="list-style-type: none"> - Hospital (See Pre-Certification Requirements) - Partial Hospitalization – two partial days equals one Inpatient day. - Physician • Outpatient treatment limited to 20 visits per Calendar Year. 	<p>90% after Deductible</p>	<p>70% after Deductible</p>
<p>Alcoholism and Drug Abuse Lifetime maximum of \$25,000 for all treatment.</p> <ul style="list-style-type: none"> • Inpatient treatment limited to 30 days per Calendar Year. <ul style="list-style-type: none"> - Hospital (See Pre-Certification Requirements) - Partial Hospitalization – two partial days equals one Inpatient day. - Physician • Outpatient treatment limited to 20 visits per Calendar Year. 	<p>90% after Deductible</p>	<p>70% after Deductible</p>
<p>Skilled Nursing Facility Must be within 7 days of a 5 day Hospital or Skilled Nursing Facility confinement, up to a maximum of 60 days per Calendar Year combined with Inpatient Rehabilitation Facility. Limited to the lesser of the Hospital's or Skilled Nursing Facility's average semi-private room rate.</p>	<p>90% after Deductible</p>	<p>70% after Deductible</p>
<p>Inpatient Rehabilitation Facility Maximum of 60 days per Calendar Year combined with Skilled Nursing Facility.</p>	<p>90% after Deductible</p>	<p>70% after Deductible</p>
<p>Home Health Care Maximum of 40 visits per Calendar Year.</p>	<p>90% after Deductible</p>	<p>70% after Deductible</p>
<p>Hospice Care</p>	<p>90% after Deductible</p>	<p>70% after Deductible</p>
<p>Private Duty Nursing Maximum of \$10,000 per Calendar Year.</p>	<p>90% after Deductible</p>	<p>70% after Deductible</p>

DESCRIPTION OF MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Maternity Care Employees and Spouses.	90% after Deductible	70% after Deductible
Well Newborn Care		
<ul style="list-style-type: none"> • Well – considered under mother’s benefits <ul style="list-style-type: none"> - hospital/nursery; - initial physician visit only; - circumcision. 	90% after Deductible	70% after Deductible
<ul style="list-style-type: none"> • Sick – considered under newborn’s benefits <ul style="list-style-type: none"> - hospital/nursery; - physician visits; - circumcision. 	90% after Deductible	70% after Deductible
Ambulance	90% after Deductible	70% after Deductible
Physical Therapy	90% after Deductible	70% after Deductible
Speech Therapy	90% after Deductible	70% after Deductible
Occupational Therapy	90% after Deductible	70% after Deductible
Durable Medical Equipment	90% after Deductible	70% after Deductible
Chiropractic Care Maximum of \$1,000 per Calendar Year, including Diagnostic Charges.	90% after Deductible	70% after Deductible
All Other Covered Charges	90% after Deductible	70% after Deductible

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS	PRESCRIPTION DRUG PROGRAM PAYS
<u>Drugs available only through the Prescription Drug Program</u>	
Retail	
<ul style="list-style-type: none"> • 30 day supply 	100% after \$10 Copay – Generic Drug \$20 Copay – Brand Name formulary Drug \$35 Copay – Brand Name non-formulary Drug
<ul style="list-style-type: none"> • 90 day supply 	100% after \$30 Copay – Generic Drug \$60 Copay – Brand Name formulary Drug \$105 Copay – Brand Name non-formulary Drug
Mail Order (90 day supply)	100% after \$20 Copay – Generic Drug \$40 Copay – Brand Name formulary Drug \$70 Copay – Brand Name non-formulary Drug

DESCRIPTION OF DENTAL BENEFITS	PLAN PAYS
Maximum Calendar Year Benefit (excluding orthodontia)	\$1,250
Separate Lifetime Orthodontia Benefit Maximum	\$1,250
Calendar Year Deductible	
• Individual	\$50
• Family	\$150
Diagnostic and Preventative Services	
<ul style="list-style-type: none"> • Oral Exam – 2 per Calendar Year • Prophylaxis – 2 per Calendar Year • Bitewing X-rays – as required • Fluoride – 1 per Calendar Year for under age 19 • Full Mouth X-rays – once per 36 months • Space Maintainers – under age 16, once in 5 years • Emergency palliative treatment – as needed 	100% no Deductible
Basic Services	80% after Deductible
Major Services	50% after Deductible
Orthodontia	50% after Deductible

DESCRIPTION OF VISION BENEFITS	PLAN PAYS
Frequency	Once every 24 months
Eye Exams (to check vision)	\$35
Spectacle Lenses and Frames or Contact Lenses	
• Single vision lenses	\$60
• Bifocal lenses	\$80
• Trifocal lenses	\$100
• Lenticular lenses	\$200
• Frames	\$30
• Contact lenses	\$200
Contact lenses prescribed for medical reasons to correct severe corneal astigmatism; unable to correct to 20/70 in better eye; severe corneal scarring; keratoconus (conical cornea); or aphakia.	\$400