# II. SCHEDULE OF BENEFITS

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Calendar Year Deductible**<br>Individual<br>Family | <br>$750<br>$2,250 | <br>$1,500<br>$4,500 |
| **Coinsurance After Deductible** | 20% | 50% |
| **Lifetime Maximum**<br>(Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses) | Unlimited | |
| **Out-of-Pocket Maximum**<br>Individual<br>Family | <br>$6,350<br>$12,700 | <br>$12,700<br>$38,100 |
| **Physician Office Visits** | 20% co-insurance<br>No Deductible | 50% co-insurance,<br>after deductible |
| **Preventative Care**<br>Members Age 19 & Older<br>Physical exams, immunization, diagnostic X-ray & Lab, mammogram (one per calendar year) | No Charge | No Charge |
| Well Child Care for Dependent Children<br>Routine Physical exam & immunization from<br>Birth – Age 18<br>(Up to 3 visits per calendar year from Age 12-18) | No Charge | No Charge |
| Eye Refraction Examination<br>(Limited to 1 per calendar year) | No Charge | No Charge |
| **Ambulatory Surgical Centers** | 10% co-insurance,<br>after deductible | 50% co-insurance,<br>after deductible |
| **Emergency Room**<br>(Waived if admitted) | $150 copay plus<br>25% co-insurance | $150 copay plus<br>25% co-insurance |
| **Hospital**<br>(Pre-Certification required)<br>Daily Hospital Room and Board, Semi Private and other allowable expenses | 20% co-insurance,<br>after deductible | 50% co-insurance,<br>after deductible |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Hospital Pre-Certification Penalty** | $600 | |
| **Pregnancy & Maternity** | 20% co-insurance, after deductible (waived for office visits) | 50% co-insurance, after deductible |
| **Mental, Nervous and Substance Abuse Expense**<br>Inpatient | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| Outpatient | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Home Health Care**<br>(Up to 100 visits per calendar year, 1 visit by home health aide equals 4 hours or less. Not covered while insure person receives hospice care) | 10% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Skilled Nursing Facility** | 10% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Hospice Care**<br>(Limited to 6 months during each insured person's lifetime for inpatient, home hospice & bereavement counseling services) | 10% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Durable Medical Equipment & Prosthetics**<br>(As medically necessary. Total rental not to exceed purchase price) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **External Prosthetic Devices** | 20% coinsurance, after deductible | 50% coinsurance, after deductible |
| -Wigs, toupees or hair pieces<br>(Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgentic alopecia- male pattern baldness) | 20% coinsurance, after deductible, and any amount over $350 maximum | 50% coinsurance, after deductible, and any amount over $350 maximum |
| **Temporomandibular Joint Disorders** | 20% co-insurance, after deductible | 50% co-insurance, after deductible |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Rehabilitative Services** | | |
| Physical Therapy (Limited to 60 visits per calendar year) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| -Physical Medicine (Limited to 60 visits per calendar year) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| -Occupational Therapy (Limited to 60 visits per calendar year) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| -Chiropractic Services (Limited to 60 visits per calendar year) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| -Speech Therapy (Limited to 50 visits per calendar year) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Acupuncture** (Up to 12 visits per calendar year and limited to $30 per visit) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |
| **Outpatient Medical Services & Supplies, Inc.** (i.e. ground & air ambulance transportation, services & disposable supplies, blood transfusions, blood processing & the cost of unreplaced blood & blood products, autologue blood) | 20% co-insurance, after deductible | 50% co-insurance, after deductible |

| PRESCRIPTION DRUG BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Retail Copayment 30-Day Supply** | | |
| Generic Drugs | 20% ($15 min, $30 max) | 50% ($15 min, $30 max) |
| Formulary Brand Name Drugs | 30% ($30 min, $60 max) | 50% ($30 min, $60 max) |
| Non-Formulary Brand Name Drugs | 30% ($45 min, $90 max) | 50% ($45 min, $90 max) |
| **Mail-Order 90-Day Supply** | | |
| Generic Drugs | 20% ($30 min, $60 max) | 50% ($15 min, $30 max) |
| Formulary Brand Name Drugs | 30% ($60 min, $120 max) | 50% ($30 min, $60 max) |
| Non-Formulary Brand Name Drugs | 30% ($90 min, $180 max) | 50% ($45 min, $90 max) |
| Self-administered injectable drugs (except insulin) | 20% of covered expense. Up to $150 copay maximum | Not Covered |