SCHEDULE OF BENEFITS FOR HEALTH SCREENING PARTICIPANTS

DEDUCTIBLE/OUT-OF-POCKET/PENALTIES

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Mandatory Hospital Pre-Admission and Outpatient Services Review ***Refer To The Section Entitled "Utilization Review Program"***		
Non-Compliance Penalty		
Inpatient Services (Medical, Surgical, Behavioral)	25% up to $1,000	
Surgical Procedures (Ambulatory)	25% up to $1,000	
Ancillary Services	25% up to $1,000	
Durable Medical Equipment	25% up to $1,000	
Diagnostic Imaging (Ambulatory)	25% up to $1,000	
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Per Confinement Co-payment	None	$300
Calendar Year Deductible		
Individual	$750	$3,000
Family	$2,250	$9,000
Note: ***The Family Deductible Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined.***		
Network Providers, and Non-Network Providers expenses will be applied equally toward the satisfaction of the Network Providers, and Non-Network Providers Deductible amounts.		
Out-of-Pocket Maximum ***(including Deductible and Medical Co-insurance)***		
Individual	$1,500	$6,000
Family	$4,500	$18,000
Note: ***The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined.***		
Network Providers and Non-Network Providers expenses will be applied equally toward the satisfaction of the Network Providers, and Non-Network Providers Out-of-Pocket Maximums.		

SPECIAL COVERAGES *Refer to Specific Section for Details*		
SUMMARY OF SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Voluntary Second Surgical Opinion	100% No Deductible	100% No Deductible
Preventive Care		
Well Child Care ***up to age 16. Includes related x-ray and lab tests, school and sports physicals, and immunizations (including flu and pneumonia shots)***		
	100% after $30 Co-payment	70% Deductible Applies ***Calendar Year Maximum $500***
Preventive Care ***over age 16. Includes related x-ray and lab tests, school and sports physicals, immunizations (including flu and pneumonia shots), pap smear, colon and rectal cancer screening, prostate exam, and other routine procedures.***		
	100% after $30 Co-payment	70% Deductible Applies ***Calendar Year Maximum $500***
Mammogram (Routine or Diagnostic)	100% No Deductible	70% Deductible Applies
Annual Colonoscopy	100% No Deductible	70% Deductible Applies
Colonoscopy performed by: Centers for Gastrointestinal Health SC (Incentive for Enrollees Only)	$300 Reimbursement Incentive	
Sigmoidoscopy	100% No Deductible	70% Deductible Applies
Screening tests for ovarian cancer for women who are at risk (including CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic exam)	100% No Deductible	70% Deductible Applies
Bone mass measurement	100% after $30 Co-payment	70% Deductible Applies
Human papillomavirus vaccine (HPV)	100% after $30 Co-payment	70% Deductible Applies
Shingles vaccine age sixty (60) and older	100% after $30 Co-payment	70% Deductible Applies
3D Mammograms (Diagnostic Only)	90% Deductible Applies	70% Deductible Applies
Worksite Health Screening thru IHS (Employee and Spouse)	100% No Deductible	
Transplant Services		
Transportation, meals and lodging	90% Deductible Applies	70% Deductible Applies
	Transportation/Meals/Lodging - $200 per day up to $10,000 per transplant	
Maternity Services		
Initial Office Visit	100% after $30 Co-payment	70% Deductible Applies
Prenatal and Delivery Services	90% Deductible Applies	70% Deductible Applies
Optometric Services ***(Excludes routine eye care, glasses and contacts)***	90% Deductible Applies	70% Deductible Applies
Charges for the diagnosis and treatment of Autism Spectrum Disorder	Benefits are based on the place/type of service	70% Deductible Applies
	Calendar Year Maximum - $36,000 per person	
Smoking Cessation (separate from prescription drug plan)	100% No Deductible	100% No Deductible
	Calendar Year Maximum - $300 ***Lifetime Maximum - $1,000***	
Diabetic Self-Management Training (includes regular foot care exams)	Benefits are based on the place/type of service	70% Deductible Applies
Emergency Care resulting from criminal sexual abuse or assault	100% No Deductible	100% No Deductible
Breast Pumps purchased at retail stores	90% Deductible Applies	90% Deductible Applies
	Lifetime Maximum - $250	

PHYSICIAN AND OFFICE SERVICES		
SUMMARY OF SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Definition of office visit Co-payment - ***Includes all office services provided the same day by the same provider or clinic, except surgical procedures, allergy injections and allergy survey, therapy, MRI, CT Scan, pulmonary function studies, cardiac catheterization, EKG, EEG, ECG and swan ganz catheterization.***		
Office Visits	100% after $30 Co-payment	70% Deductible Applies
Surgery	90% Deductible Applies	70% Deductible Applies
Diagnostic X-Ray & Lab (in conjunction with an office visit)	100% No Deductible	70% Deductible Applies
Independent Lab, Radiologist & Pathologist (in conjunction with an office visit)	100% No Deductible	*70% Deductible Applies
	Services Performed by a Non-Network Provider Which Relate To Network Provider Services will be payable at the Network Provider rate.	
Diagnostic Testing such as MRI, PET and CAT Scans	90% Deductible Applies	70% Deductible Applies
Independent Lab, Radiologist & Pathologist	90% Deductible Applies	*70% Deductible Applies
	Services Performed by a Non-Network Provider Which Relate To Network Provider Services will be payable at the Network Provider rate.	
Allergy Injections/Testing	90% Deductible Applies	70% Deductible Applies
Chemotherapy	90% Deductible Applies	70% Deductible Applies
Physical, Occupational & Speech Therapy (including preventive physical therapy for multiple sclerosis)	90% Deductible Applies	70% Deductible Applies
	Calendar Year Maximum – 30 Visits per Therapy	
Cardiac Rehabilitation Therapy	90% Deductible Applies	70% Deductible Applies
	Calendar Year Maximum – 36 Sessions ***Services rendered within six months of inpatient admission for myocardial infarction, coronary bypass surgery, stable angina pectoris, angioplasty, cardiac valve surgery or other major surgery***	
Chiropractic Services		
Office Visits	90% Deductible Applies	70% Deductible Applies
Manipulations	90% Deductible Applies	70% Deductible Applies
X-Rays	90% Deductible Applies	70% Deductible Applies
	Calendar Year Maximum – 25 Visits	
Podiatric Services – Routine foot care is excluded (except for diabetic care)		
Office Visits	100% after $30 Co-payment	70% Deductible Applies
Surgery	90% Deductible Applies	70% Deductible Applies
X-Ray & Lab	100% No Deductible	70% Deductible Applies
Orthotics	Not Covered	Not Covered
Infertility Services		
Initial Diagnostic Testing	Benefits are based on the type of service	70% Deductible Applies
Infertility Treatment	Benefits are based on the type of service	70% Deductible Applies
	Lifetime Maximum - $25,000 (including prescription drugs)	
TMJ Services		
Office Visits	90% Deductible Applies	70% Deductible Applies
Surgery & Related Services	90% Deductible Applies	70% Deductible Applies
Appliances	90% Deductible Applies	70% Deductible Applies
Physical Therapy	90% Deductible Applies	70% Deductible Applies
All Other Covered Services	90% Deductible Applies	70% Deductible Applies
	Lifetime Maximum - $2,500	
Mental & Nervous Disorder	100% after $30 Co-payment	70% Deductible Applies
Substance Abuse	100% after $30 Co-payment	70% Deductible Applies
Other Covered Services	90% Deductible Applies	70% Deductible Applies

OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Emergency Room - ***If admitted, benefits are paid at the applicable Deductible and Co-insurance levels.***	100% after $150 Co-payment, No Deductible	100% after $150 Co-payment, No Deductible
Urgent Care	100% after $30 Co-payment	70% Deductible Applies
Diagnostic X-Ray & Lab	90% Deductible Applies	70% Deductible Applies
Pre-Admission Testing	90% Deductible Applies	70% Deductible Applies
Surgeon/Surgery	90% Deductible Applies	70% Deductible Applies
Physical, Occupational & Speech Therapy (including preventive physical therapy for multiple sclerosis)	90% Deductible Applies	70% Deductible Applies
	Calendar Year Maximum – 30 Visits per Therapy	
Cardiac Rehabilitation Therapy	90% Deductible Applies	70% Deductible Applies
	Calendar Year Maximum – 36 Sessions ***Services rendered within six months of inpatient admission for myocardial infarction, coronary bypass surgery, stable angina pectoris, angioplasty, cardiac valve surgery or other major surgery***	
Chemotherapy & Radiation Therapy	90% Deductible Applies	70% Deductible Applies
Assistant Surgeon (when Medically Necessary), Anesthesiologist, Pathologist, Radiologist & Consulting Physician	90% Deductible Applies	*70% Deductible Applies
	****Services Performed by a Non-Network Provider Which Relate To Network Provider Services will be payable at the Network Provider rate.***	
Mental & Nervous Disorder	90% Deductible Applies	70% Deductible Applies
Substance Abuse	90% Deductible Applies	70% Deductible Applies
Other Covered Services	90% Deductible Applies	70% Deductible Applies

INPATIENT HOSPITAL

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Room, Board & Miscellaneous	90% Deductible Applies	$300 Co-payment, then 70% Deductible Applies
Nursery	90% Deductible Applies	$300 Co-payment, then 70% Deductible Applies
	Baby & Mother's Charges Will Be Separate	
Diagnostic X-Ray & Lab	90% Deductible Applies	$300 Co-payment then 70% Deductible Applies
Surgeon/Physician Visits	90% Deductible Applies	70% Deductible Applies
Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician	90% Deductible Applies	*70% Deductible Applies
	****Services Performed by a Non-Network Provider Which Relate To Network Provider Services will be payable at the Network Provider rate.***	
Mental & Nervous Disorder	90% Deductible Applies	$300 Co-payment, then 70% Deductible Applies
Substance Abuse	90% Deductible Applies	$300 Co-payment, then 70% Deductible Applies
Other Covered Services	90% Deductible Applies	$300 Co-payment, then 70% Deductible Applies

OTHER COVERED SERVICES		
SUMMARY OF SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Extended Care Facility	90% Deductible Applies	70% Deductible Applies
	Calendar Year Maximum – 60 Days, $800 per day. Admission must begin within 14 days of a Hospital stay or related confinement in an Extended Care Facility.	
Home Health Care	90% Deductible Applies	70% Deductible Applies
	Calendar Year Maximum - 40 Visits	
Hospice Care/Bereavement Counseling	90% Deductible Applies	70% Deductible Applies
	Lifetime Maximum - $25,000	
Naprapathic Services	80% Deductible Applies	80% Deductible Applies
	Calendar Year Maximum - $1,000	
Nutritional Counseling	Benefits are based on the place of service	70% Deductible Applies
Ambulance	80% Deductible Applies	80% Deductible Applies
Durable Medical Equipment	80% Deductible Applies	80% Deductible Applies
	Limited to the lesser of the purchase price or the total anticipated rental charges. Pre-approval is required. Calendar Year Maximum - $2,500	
Prosthetic Appliances	80% Deductible Applies	80% Deductible Applies
	Includes replacements which are medically necessary or required by pathological change or normal growth.	

PRESCRIPTION DRUG PLAN	
RETAIL PRESCRIPTION PLAN	
If obtained through the Prescription Drug Plan – 100% after satisfaction of applicable Co-payment: - **Per 30 or 90 day supply:**	
Generic	$10.00
referred Brand	$30.00
Non-Preferred Brand	$50.00
Specialty Drugs	$100.00
MAIL ORDER PRESCRIPTION PLAN	
If obtained through the Mail Order Prescription Drug Plan – 100% after satisfaction of applicable Co-payment: - **Per 90 day supply**	
Generic	$20.00
Preferred Brand	$60.00
Non-Preferred Brand	$100.00
Specialty Drugs	$200.00
PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS	Co-payment plus 25% of the cost if a Non-participating pharmacy is used, claim needs to be submitted to the Prescription Drug Plan vendor.
COVERAGE INCLUDES	**COVERAGE EXCLUDES**
♦ Federal Legend Drugs	♦ Glucowatch products
♦ Insulin	♦ Rogaine
♦ Diabetic Supplies	♦ Emergency contraceptives
♦ Needles & Syringes	♦ Anti-Obesity medication
♦ Oral, transdermal, intravaginal and injectable contraceptives	♦ OTC Counterparts
♦ Impotency drugs (subject to quantity limits)	♦ Cosmetic Drugs
♦ Injectables	♦ Fertility medication
♦ Retin-A thru age 35	
♦ Synagis/Respigam	
♦ Legend pediatric fluoride vitamins	
♦ Smoking Cessation Products (separate from medical) ***$300 Calendar Year Maximum, $1,000 Lifetime Maximum***	

For Additional Information Regarding The Drugs Covered Under The Prescription Drug Plan, Contact The Prescription Drug Plan Vendor Listed On Your I.D. Card.

Acute Medications - those drugs used primarily for short-term use such as antibiotics, pain relievers, etc. Maximum thirty (30) day supply.

Maintenance Medications – those drugs used primarily to treat chronic conditions such as heart medications, high blood pressure medications, etc. Maximum ninety (90) day supply with three (3) refills.

Expenses Related To Office Visit Co-payments, Prescription Drug Co-payments, Chiropractic Care, Physical, Occupational And Speech Therapy, TMJ Treatment, Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.

Any Maximums Which Are Stated In Dollar Amounts, Number Of Days Or Number Of Treatments And Which Limit Either The Maximum Benefits Payable Or The Maximum Allowable Covered Expense Are The Combined Maximums Under The Network Providers And Non-Network Providers Level Of Benefits.