SIHWIT PLAN B SCHEDULE OF BENEFITS

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	
Calendar Year Deductible		
Individual	$5,000	$10,000
Family	$10,000	$20,000
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, Medical Co-payments, Prescription Drug Co-payments and Medical Co-insurance)***		
Individual	$6,350	$12,800
Family	$12,700	$25,600
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		
Expanded Women's Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA).	100% No Deductible	60% Deductible Applies
Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) include the following:	100% No Deductible	60% Deductible Applies
• ***Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;***		
• ***Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;***		
• ***Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and***		
• ***Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.***		
• ***The complete list of recommendations and guidelines can be found at: http://www.hhs.gov/healthcare/prevention/index.html***		
Preventive Care (*Also includes school and sports physicals)*	100% No Deductible	60% Deductible Applies
Mammogram (*Routine or Diagnostic)*	100% No Deductible	60% Deductible Applies
Annual Colonoscopy *(Routine or Diagnostic)*	100% No Deductible	60% Deductible Applies
Colonoscopy performed by Centers of Gastrointestinal Health SC	$300 Reimbursement Incentive	
Sigmoidoscopy	100% No Deductible	60% 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	60% Deductible Applies
Bone mass measurement	100% No Deductible	60% Deductible Applies
Human papillomavirus vaccine (HPV)	100% No Deductible	60% Deductible Applies
Shingles vaccine age sixty (60) and older	100% No Deductible	60% Deductible Applies
3D Mammograms (Diagnostic Only)	80% Deductible Applies	60% Deductible Applies
Worksite Health Screening thru IHS (Employee and Spouse)	100% No Deductible	
Transplant Services		
Transportation, meals and lodging	80% Deductible Applies	60% Deductible Applies
	Transportation/Meals/Lodging - $200 per day up to $10,000 per transplant	
Optometric Services ***(Excludes routine eye care, glasses and contacts)***	80% Deductible Applies	60% Deductible Applies
Autism Spectrum Disorder	80% Deductible Applies	60% Deductible Applies
	Calendar Year Maximum - $36,000 per person	
Smoking Cessation (separate from the Prescription Drug Plan)	100% No Deductible	100% No Deductible
	Calendar Year Maximum – Two Treatments per Calendar Year	
Diabetic Self-Management Training (includes regular foot care exams)	80% Deductible Applies	60% Deductible Applies
Emergency Care resulting from criminal sexual abuse or assault	100% No Deductible	100% No Deductible

PHYSICIAN AND OFFICE SERVICES

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visits	80% Deductible Applies	60% Deductible Applies
Surgery	80% Deductible Applies	60% Deductible Applies
Diagnostic X-Ray & Lab (including MRI, PET and CT Scans)	80% Deductible Applies	60% Deductible Applies
Independent Lab, Radiologist & Pathologist	80% Deductible Applies	*60% 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	80% Deductible Applies	60% Deductible Applies
Allergy Testing	80% Deductible Applies	60% Deductible Applies
Chemotherapy	80% Deductible Applies	60% Deductible Applies
Physical, Occupational & Speech Therapy (including preventive physical therapy for multiple sclerosis)	80% Deductible Applies	60% Deductible Applies
	Calendar Year Maximum – 30 Visits per therapy	
Cardiac Rehabilitation Therapy	80% Deductible Applies	60% 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	80% Deductible Applies	60% Deductible Applies
Manipulations	80% Deductible Applies	60% Deductible Applies
X-Rays	80% Deductible Applies	60% Deductible Applies
	Calendar Year Maximum – 15 Visits	
Podiatric Services – ***Routine foot care is excluded (except for diabetic care)***		
Office Visits	80% Deductible Applies	60% Deductible Applies
Surgery	80% Deductible Applies	60% Deductible Applies
X-Ray & Lab	80% Deductible Applies	60% Deductible Applies
Orthotics	Not Covered	Not Covered
Infertility Services		
Initial Diagnostic Testing	80% Deductible Applies	60% Deductible Applies
Infertility Treatment	80% Deductible Applies	60% Deductible Applies
	Lifetime Maximum - $25,000 (including prescription drugs)	
TMJ Services		
Office Visits	80% Deductible Applies	60% Deductible Applies
Surgery & Related Services	80% Deductible Applies	60% Deductible Applies
Appliances	80% Deductible Applies	60% Deductible Applies
Physical Therapy	80% Deductible Applies	60% Deductible Applies
All Other Covered Services	80% Deductible Applies	60% Deductible Applies
	Lifetime Maximum - $2,500	
Mental & Nervous Disorder	80% Deductible Applies	60% Deductible Applies
Substance Abuse	80% Deductible Applies	60% Deductible Applies
Other Covered Services	80% Deductible Applies	60% 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.***	80% Network Provider Deductible Applies	
Urgent Care	80% Deductible Applies	60% Deductible Applies
Diagnostic X-Ray & Lab	80% Deductible Applies	60% Deductible Applies
Pre-Admission Testing	80% Deductible Applies	60% Deductible Applies
Surgeon/Surgery	80% Deductible Applies	60% Deductible Applies
Physical, Occupational & Speech Therapy (including preventive physical therapy for multiple sclerosis)	80% Deductible Applies	60% Deductible Applies
	Calendar Year Maximum – 30 Visits per therapy	
Cardiac Rehabilitation Therapy	80% Deductible Applies	60% 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	80% Deductible Applies	60% Deductible Applies
Assistant Surgeon (when Medically Necessary), Anesthesiologist, Pathologist, Radiologist & Consulting Physician	80% Deductible Applies	*60% Deductible Applies
	****Services Performed by a Non-Network Provider Which Relate To Network Provider Services will be payable at the Network Benefit Level***	
Mental & Nervous Disorder	80% Deductible Applies	60% Deductible Applies
Substance Abuse	80% Deductible Applies	60% Deductible Applies
Other Covered Services	80% Deductible Applies	60% Deductible Applies

INPATIENT HOSPITAL

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Room, Board & Miscellaneous	80% Deductible Applies	60% Deductible Applies
Nursery	80% Deductible Applies	60% Deductible Applies
	Baby & Mother's Charges Will Be Separate	
Diagnostic X-Ray & Lab	80% Deductible Applies	60% Deductible Applies
Surgeon	80% Deductible Applies	60% Deductible Applies
Physician Visits	80% Deductible Applies	60% Deductible Applies
Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician	80% Deductible Applies	*60% 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	80% Deductible Applies	60% Deductible Applies
Substance Abuse	80% Deductible Applies	60% Deductible Applies
Other Covered Services	80% Deductible Applies	60% Deductible Applies

OTHER COVERED SERVICES

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Extended Care Facility	80% Deductible Applies	60% Deductible Applies
	Calendar Year Maximum – 60 Days. Admission must begin within 14 days of a Hospital stay or related confinement in an Extended Care Facility.	
Home Health Care	80% Deductible Applies	60% Deductible Applies
	Calendar Year Maximum - 40 Visits	
Hospice Care/Bereavement Counseling	80% Deductible Applies	60% Deductible Applies
	Lifetime Maximum - $25,000	
Naprapathic Services	80% Deductible Applies	60% Deductible Applies
	Calendar Year Maximum - $1,000	
Nutritional Counseling	80% Deductible Applies	60% Deductible Applies
Ambulance	80% Deductible Applies	80% PPO Provider 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 day supply:**	
Generic	$10.00
Preferred Brand	$30.00
Non-Preferred Brand	$50.00
Specialty Drugs	$100.00
Generic FDA approved forms of Contraceptives for Women	100% No Co-payment
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
Generic FDA approved forms of Contraceptives for Women	100% No Co-payment
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 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	
♦ FDA approved forms of Contraceptives for Women	
♦ Immunizations/Vaccinations	
♦ Legend pediatric fluoride vitamins	
♦ Smoking Cessation Products (separate from medical)	

For Additional Information Regarding The Drugs Covered Under The Prescription Drug Plan, Contact The Prescription Drug Company 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 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.