SCHEDULE OF BENEFITS – Effective 1.1.2019

With regard to PPO services, percentage refers to percentage of Preferred Provider Option's negotiated fee schedule. With regard to Non-PPO and Out-of-Area services, percentage refers to percentage of Usual and Customary Charges.

Plan of Benefits

Eligible Employees and Eligible Dependents, except as indicated

Death Benefit – Employee ..... Full Time $5,000/Part Time $3,000

Accidental Death and Dismemberment Insurance Benefit – Employee $10,000

Income Protection Benefit – Employee

Maximum Amount ..... 55% of weekly Earnings up to $161.00 per week for full time

Maximum Amount ..... 55% of weekly Earnings up to $49.00 per week for part time

Maximum Period ..... 26 weeks

Date Benefits start ..... First day Accident
First day Hospital Confined
First day Outpatient Surgery
Eighth day Sickness

Comprehensive Medical Expense Benefit

Calendar Year Deductible:

Single $500

Family $1,000

Medical Out-of-Pocket (OOP) Maximum:

Single $2,500

Family $7,500

Non-PPO Deductible (applies to each Non-PPO Hospital Confinement) $550

Non-Compliance Penalty (applies to each inpatient confinement, surgery, advanced diagnostic testing, or other service where Pre-authorization is required for which Pre-authorization is not obtained) $100

Percent of Covered Expenses Payable per Calendar Year:

Hospital:

PPO and Out-of-Area ..... 90% after Deductible*

Non-PPO ..... 75% of a discounted fee after Deductible*

Emergency Room Care:

PPO ..... 90% after Deductible*

Non-PPO ..... 90% after Deductible*

**Services outlined in the Schedule of Benefits that are subject to the Non-Compliance Deductible*

Emergency Medical Transportation:

PPO ..... 80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Surgery for which a Second Surgical Opinion is required but not obtained..... 50% after Deductible*

Inpatient Rehabilitation:

PPO and Out-of-Area ..... 90% after Deductible*

Non-PPO ..... 75% of a discounted fee after Deductible*

Outpatient surgery:

PPO ..... 80% after Deductible*

Non-PPO ..... 80% of a discounted fee after Deductible*

Primary Care/Specialist Visit:

PPO ..... 80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Urgent Care:

PPO ..... 80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Most other Covered Expenses (unless otherwise noted)..... 80%

Preventive Care:

PPO ..... No charge, not subject to Deductible

Non-PPO ..... 80% after Deductible

Diagnostic test:

PPO ..... 80% after Deductible**

Non-PPO ..... 75% of a discounted fee after Deductible**

***Deductible does not apply to outpatient lab tests*

Imaging (CT/PET scans, MRIs):

PPO ..... 80% after Deductible*

Non-PPO ..... 75% of a discounted fee after Deductible*

Mental Health and Substance Use Disorder:

Outpatient:

PPO .....80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Inpatient:

PPO .....90% after Deductible*

Non-PPO ..... 75% of a discounted fee after Deductible*

Home Health Care:

PPO .....80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Occupational Therapy:

Number of sessions per Acute Occurrence .....25 sessions

PPO .....80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Percent of covered additional benefits if not pre-authorized (more than 25 session) 50%

Physical Therapy, Prolo Therapy, and Acupuncture:

Number of sessions per Acute Occurrence .....25 sessions

PPO .....80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Percent of additional benefits if not pre-authorized (more than 25 sessions) 50%

Speech Therapy (as described in Section 11.07):

Number of sessions per Acute Occurrence .....25 sessions

PPO .....80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Percent of covered additional benefits if not pre-authorized (more than 25 sessions) 50%

Chiropractic Care (as described in Section 11.07):

PPO .....80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible

Calendar year maximum .....$2,200 per person

Cardiac and Pulmonary Rehabilitation:

Number of sessions per Acute Occurrence.....30 sessions

PPO.....80% after Deductible

Non-PPO..... 80% of a discounted fee after Deductible

Skilled Nursing Care:

PPO.....80% after Deductible

Non-PPO..... 80% of a discounted fee after Deductible

Pre-authorization required if skilled nursing care received in residential care center or Hospital.

Durable Medical Equipment:

PPO.....80% after Deductible*

Non-PPO..... 80% of a discounted fee after Deductible*

Hospice:

PPO.....80% after Deductible

Non-PPO..... 80% of a discounted fee after Deductible

Pre-authorization required if Hospice care received in residential care center or Hospital.

Nutritional Counseling/Bariatric Treatment and Management/Bariatric Surgery:

PPO.....80% after Deductible*

Non-PPO..... 80% of a discounted fee after Deductible*

Nutritional Counseling Maximum per Calendar Year..... 4 visits per person

Bariatric Treatment and Management Maximum per Calendar Year..... 6 visits per person

Pre-authorization required for Nutritional Counseling, Bariatric Treatment and Management, and Bariatric Surgery.

Pain Management Treatment:

Number of sessions per Acute Occurrence……25 sessions

PPO..... 80%

Non-PPO..... 50%

Pre-authorization required for IV sedation in conjunction with outpatient epidural or other pain management interventional injections or procedures.

Hearing Aid:

Percent of Covered Expenses Payable..... 80%

Maximum per 5 Consecutive Year Period.....$500

Intentionally Destructive Act (unless caused by or related to an underlying medical condition):

Percent of Covered Expenses Payable 50%

Hospital Charges for Dental Surgery:

Percent of Covered Expenses Payable 50%*

Treatment of Varicose Veins (if medically necessary)

Lifetime Maximum .....$2,200 per leg

Voice Communication Machine:

Lifetime Maximum $7,500

Dental Benefit:

Individuals age 19 years and older..... 100% up to $150 Annual Maximum per person

Individuals under age 19 ..... 100% for oral exams (1 per Calendar Year), cleanings (2 per Calendar Year), fillings, and x-rays

Dental surgery……50% of Covered Expenses

Vision Benefit:

Maximum.....$100 per person per Calendar Year

Individuals under age 19 ..... 100% for exam and lenses and frames or contact lenses once per Calendar Year

Prescription Drug Benefit:

Prescription Drug Benefit ..... 100% after applicable Co-pay per prescription when filled at a Participating Pharmacy, up to the Prescription Drug Out-of-Pocket (OOP) Maximum

Prescription Drug Out-of-Pocket (OOP) Maximum ..... $4,850 Single/$7,200 Family

30 Day Supply Retail and Mail Order:

Co-pay for Tier Zero Drug.....$0

Co-pay for Tier One Drug.....$10

Co-pay for Tier Two Drug.....$21

Co-pay for Tier Three Drug.....$40

Specialty Drugs.....$40

90 Day Supply Maintenance Drugs through Mail Order:

Co-pay for Tier Zero Drug.....$0

Co-pay for Tier One Drug.....$12

Co-pay for Tier Two Drug.....$36

Co-pay for Tier Three Drug..... Not Covered

Specialty Drugs..... Not Covered

Prescription Drugs are not subject to the Medical Deductible.

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