

MEDICAL COVERAGE SUMMARY INDEMNITY PLAN

**APPLIES TO: ACTIVE PUBLIC EMPLOYEES, COBRA BENEFICIARIES,
AND THEIR DEPENDENTS
EFFECTIVE JANUARY 1, 2015**

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
DEDUCTIBLE	Per calendar year. (Carryover does not apply) Applies only to major medical benefits.	None	\$200 Individual \$400 Family
OUT-OF-POCKET MAXIMUM	Per calendar year. Includes the calendar year deductible and Coinsurance amounts. Does not include Copayments, prescription drug Copayments, amounts in excess of the Reasonable and Customary, amounts in excess of the Plan maximums, any charges for services which are not covered, and charges for Mental Illness and Substance Abuse, including treatment of alcoholism. Applies only to major medical benefits.	None	\$500 Individual \$1,000 Family
LIFETIME MAXIMUM	Applies only to non-essential, major medical benefits.	No Limit	\$1,000,000

Radiologist, Anesthesiologists, Pathologists and Emergency Care: If you have a covered surgical procedure or inpatient stay when attended and admitted by a Preferred Provider, services by the associated radiologist, anesthesiologist or pathologist, will be payable at the in-network benefit level. Emergency care and associated professional fees (anesthesiologist, pathologist, radiologist) rendered in a Hospital Emergency room will be payable at the in-network benefit level when rendered by either a non-preferred or Preferred Provider. The treatment must be for an Emergency as defined in the Plan. Follow-up care will be payable according to the Coverage Summary.

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
ACUPUNCTURE	The Plan covers Medically Necessary acupuncture for pain management.	\$20 Copay	80%
ALLERGY CARE -Office Visit -Treatment (Injections) -Serum -Laboratory & Scratch Testing		\$20 Copay 100% 100% \$20 Copay	80% 80% 80% 80%
AMBULANCE		100%	80%
ANESTHESIA -Inpatient -Outpatient -Office		100% 100% 100%	80% 80% 80%
BIOFEEDBACK		Not Covered	Not Covered
BLOOD AND BLOOD PRODUCTS		100%	80%
CARDIAC REHABILITATION -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHEMOTHERAPY -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHIROPRACTOR		First \$5000 paid at 100%, then next \$3400 paid at 50% per calendar year	80%
CONVALESCENT/SKILLED NURSING FACILITY	Maximum of 30 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.	100%	80%
DENTAL CARE COVERED UNDER MEDICAL PLAN -Accidental Injury to Teeth -Oral Surgery	Covered when Medically Necessary and not covered under Dental Plan.	100% 100%	80% First \$1,400 payable at 100%, after deductible; then 80%
DIABETIC TREATMENT -Education -Supplies and Equipment		\$20 Copay 100%	80% 80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
DIAGNOSTIC X-RAYS AND IMAGING TESTS -Independent Facility -Outpatient Hospital -Physician's Office		\$20 Copay \$20 Copay \$20 Copay	First \$150 paid at 100% per calendar year; then 80% First \$150 paid at 100% per calendar year; then 80% First \$150 paid at 100% per calendar year; then 80%
HIGH TECH IMAGING (SUCH AS MRI, MRA, PET AND CAT SCANS)		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
DIALYSIS OR HEMODIALYSIS -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
DURABLE MEDICAL EQUIPMENT (DME) <i>Including, but not limited to:</i> -Disposable Medical Supplies -Prosthetics (External and Internal) -Wigs -Foot Orthotics -Orthotics (Braces) -Oxygen	Covered when Medically Necessary. Under the age of 19 has no limit, but over age 19 is limited to one wig per Lifetime. Covered when Medically Necessary. Covered when Medically Necessary.	100% 100% \$20 Copay \$20 Copay \$20 Copay 100%	80% 80% 80% 80% 80%
EATING DISORDERS		100%	80%
ENTERAL FORMULA	Covered if it is the patient's only source of nutrition. The Plan does not cover nutritional supplements.	100%	80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
FAMILY PLANNING SERVICES			
-Elective Sterilization Procedures	Covered for Employee or spouse. Reversal is not covered.	Tubal Ligation = 100% Vasectomy = \$20 Copay	80%
-Voluntary Termination of Pregnancy	Covered for Employee, spouse, or Dependent.	\$20 Copay	80%
-Infertility Treatment	The Plan covers Medically Necessary diagnostic services and treatment of the Sickness or Injury that is the cause of infertility.	Not Covered	Not Covered
-Contraceptive Drugs and Devices	The Pharmacy Benefit Manager requires letter of Medical Necessity.	Covered under the Prescription Drug Plan	Covered under the Prescription Drug Plan
-Contraceptive Management Office Visit		Not Covered	Not Covered
-Early Intervention Services	The Plan covers learning disorders diagnosed as ADD, ADHD, Central Auditory Processing Disorders, Dyslexia, Dysgraphia, Dyscalculia, Dyspraxia, Apraxia or Hyperlexia.	\$20 Copay	80%
FOREIGN CARE			
-Emergent	Only covered for emergency situations.	100%	100%
-Non-Emergent	Current exchange rate applies.	Not Covered	80%
GENETIC TESTING	The Plan covers Genetic Testing, and associated counseling, when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature.	\$20 Copay	80%
GROWTH HORMONES	The Plan covers when Medically Necessary.	\$20 Copay	80%
HOME HEALTH CARE	Maximum of 60 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.		
-Aide, Nurse, or any other Authorized Agency Employee		100%	80%
-Home IV Therapy and Respiratory Care		100%	80%
HOSPICE CARE	For Covered Family Member diagnosed with a terminal illness and a life expectancy of six months or less.		
-Inpatient		100%	80%
-Home		100%	80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
HOSPITAL FACILITY			
<u>Inpatient Hospital</u>	Maximum of 30 days for tuberculosis, contagious diseases and after effects of these conditions. Maximum of 30 days in all hospitals operated by a governmental body or agency, except when operated by a county or municipality.	100%	First 120 days paid at 100%; then \$5.00 per day for an additional 245 days in same benefit period with remaining charges paid at 80%
<u>Outpatient Hospital</u>			
-Emergency Room for a medical Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Emergency Room used for a Non-Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Outpatient Surgical Center		100%	80%
-Clinic		\$20 Copay	80%
INFUSION THERAPY	Includes chelation therapy.	100%	80%
LABORATORY			
-Independent Facility		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Outpatient Hospital		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Physician's Office		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
MASSAGE THERAPY (When rendered by a Licensed Massage Therapist)		Not Covered	Not Covered
MATERNITY CARE-MOTHER (Refer to Diagnostic X-rays, Imaging Tests and Laboratory for benefits related to maternity)			
-Inpatient Hospital	Pre-Certification is recommended if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section.	100%	100%; not subject to deductible
-Physician for Prenatal Care and Delivery		\$20 Copay	80%
-Birthing Center		100%	80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
MENTAL ILLNESS SERVICES	Coinsurance does not accrue toward the Out-of-Pocket Maximum.		
-Inpatient	(Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Mental Illness admission.	100%	100% Maximum of 30 days per calendar year.
-Inpatient Physician		100%	80%
-Outpatient/Office	Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Substance Abuse Treatment.	\$20 Copay	80%
MODIFIED FOOD PRODUCT		Not Covered	Not Covered
NEWBORN CARE (Prior to Discharge)	When Plan covers both Mother and Baby		
-Hospital	Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Physician		100%	80%
-Newborn Circumcision		100%	80%
NEWBORN CARE (Prior to Discharge)	When Plan covers the Baby but not the Mother		
-Hospital	Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Physician		100%	80%
-Newborn Circumcision		100%	80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
NUTRITIONAL COUNSELING	Covered for Family Members with diabetes only.	\$20 Copay	80%
OBESITY TREATMENT	The Plan only covers charges for surgical procedures in cases of morbid obesity. The Plan does not cover charges for treatment of obesity, weight reduction, diet programs (Weight Watchers, Nutrisystem, etc.) or diet supplements.	100%	80%
OCCUPATIONAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%
ORGAN TRANSPLANTS	The Plan does not cover expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Medical Plan will be secondary. If an organ is sold, not donated, no benefits are paid for the donor's expenses.	100%	80%
PHYSICAL REHABILITATION FACILITY		100%	80%
PHYSICAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PHYSICIAN			
-Inpatient		100%	First \$8.00 per day, up to a \$960 maximum, paid at 100%; then 80%
-Office		\$20 Copay	80%
-Home		\$20 Copay	80%
<u>Consultation (Specialist)</u>			
-Inpatient		100%	80%
-Outpatient		\$20 Copay	80%
-Office		\$20 Copay	80%
<u>Second Medical Opinion</u>		\$20 Copay	80%
PREADMISSION TESTING		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
PREVENTATIVE/WELL CARE			
-Bone Density Testing		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Colonoscopy/Sigmoidoscopy		100%	80%
-GYN Office Visit	Maximum of 2 visits per calendar year.	\$20 Copay	80%
-Mammogram	Maximum of 1 per calendar year, unless Medical Necessity.	\$20 Copay	80%
-PAP Smear	Maximum of 2 per calendar year.	\$20 Copay When performed during GYN Office Visit an additional Copay will not be taken.	80%
-Prostate Cancer Screening (PSA)	Maximum of 2 per calendar year.	\$20 Copay	80%
-Routine Adult Physical	Maximum of 1 per calendar year. (includes appropriate labs and x-rays) The Plan does not cover immunizations, HPV vaccine, and Flu vaccinations.	\$20 Copay	80%
-Well Child Care	Up to and including age 12. (includes appropriate labs, x-rays and immunizations)	\$20 Copay	80%
-Hearing Exams		\$20 Copay	80%
-Hearing Aids		\$20 Copay	80%
-Eye Exams		Not Covered	Not Covered
-Frames and Lenses		Not Covered	Not Covered

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PRIVATE DUTY NURSING		Not Covered	Not Covered
RADIATION THERAPY			
-Outpatient Hospital		100%	First \$320 paid at 100% per calendar year; then 80%
-Any other place of service		100%	First \$320 paid at 100% per calendar year; then 80%
RESPIRATORY THERAPY			
-Outpatient Hospital		100%	80%
-Any other place of service		100%	80%
SLEEP DISORDERS	The Plan only covers sleep studies and apnea monitors.	\$20 Copay	80%
SMOKING CESSATION PRODUCTS		Not Covered	Not Covered
SPEECH THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%
SUBSTANCE ABUSE TREATMENT	Coinsurance does not accrue toward the Out-of-Pocket Maximum.		
-Detoxification		Included in Inpatient Rehabilitation	Included in Inpatient Rehabilitation
-Inpatient Rehabilitation	(Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Substance Abuse admission.	100%	100% Maximum of 30 days per calendar year.
-Inpatient Physician		100%	80%
-Outpatient/Office	Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Mental Illness Services.	\$20 Copay	80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery) <u>Surgeon</u> -Inpatient -Outpatient -Office <u>Assistant Surgeon</u> <u>Second Surgical Opinion</u> -Voluntary -Mandatory	Maximum of 20% of the Surgeon's fee.	100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	80%
		\$20 Copay Not Required	80% Not Required

Out-of-Network Surgical Allowance Schedule

Appendectomy	\$280
Breast, removal of benign tumor	\$105
Fracture of femur, neck, intertrochanteric, simple or compound, open reduction	\$560
Fracture of radius and ulna, simple closed reduction	\$175
Gall bladder, removal of	\$420
Heart, removal of intra cardiac tumor	\$210
Hemorrhoidectomy, internal and external	\$245
Herniotomy, inguinal (single)	\$700
Hip, fusion of	\$420
Hysterectomy, total corpus and cervix	\$560
Mastoidectomy, modified radical or radical without skin graft	\$560
Prostatectomy, suprapubic, one or two stages	\$630
Spine and Spinal Cord, laminotomy for removal of intervertebral discs, lumbar	\$630
Stomach, partial removal of	\$105
Tonsils and Adenoids, removal of	\$140
Under age 18	
18 years or over	

- Above surgeries payable at 100% of allowance, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.
- For surgeries not listed in this schedule, maximum allowance is \$1,400 payable at 100%, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.

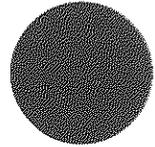
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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY CENTER (Freestanding Surgical Facility)		100%	80%
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)	The Plan only covers diagnostic x-rays and testing. Any treatment, including surgery, is not covered.	\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
URGENT CARE FACILITY		100%	80%

PRESCRIPTION DRUG EXPENSE BENEFIT

TYPE OF PROGRAM	IMPORTANT PROVISIONS	IN-NETWORK PHARMACY BENEFIT
RETAIL DRUGS	Copay is for each separate prescription or refill.	\$10.00 Copay – Generic Drug \$20.00 Copay – Brand Name Drug
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply. Copay is for each separate prescription or refill.	\$10.00 Copay – Generic Drug \$20.00 Copay – Brand Name Drug
DIABETIC SUPPLIES AND EQUIPMENT	Diabetic supplies and equipment that are covered as a Medical Expense Benefit will not be covered as a Prescription Drug Expense Benefit.	See benefit for Retail and Mail Order Maintenance Drugs.
<p>Copays under the Prescription Drug Expense Benefit do not count toward the Medical Out-of-Pocket Maximum.</p> <p>The Medical Expense Benefit portion of the Plan covers prescription drugs purchased from an Out-of-Network Pharmacy payable at 80%; subject to the Medical Deductible. Copays are not covered.</p>		
<p>Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries.</p> <p>Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.</p>		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

MEDICAL COVERAGE SUMMARY INDEMNITY PLAN



**APPLIES TO: ACTIVE POLICEMEN, COBRA BENEFICIARIES,
AND THEIR DEPENDENTS
EFFECTIVE JANUARY 1, 2015**

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
DEDUCTIBLE	Per calendar year. (Carryover does not apply) Applies only to major medical benefits.	None	\$200 Individual \$400 Family
OUT-OF-POCKET MAXIMUM	Per calendar year. Includes the calendar year deductible and Coinsurance amounts. Does not include Copayments, prescription drug Copayments, amounts in excess of the Reasonable and Customary, amounts in excess of the Plan maximums, any charges for services which are not covered, and charges for Mental Illness and Substance Abuse, including treatment of alcoholism. Applies only to major medical benefits.	None	\$500 Individual \$1,000 Family
LIFETIME MAXIMUM	Applies only to non-essential, major medical benefits.	No Limit	\$1,000,000

Radiologist, Anesthesiologists, Pathologists and Emergency Care: If you have a covered surgical procedure or inpatient stay when attended and admitted by a Preferred Provider, services by the associated radiologist, anesthesiologist or pathologist, will be payable at the in-network benefit level. Emergency care and associated professional fees (anesthesiologist, pathologist, radiologist) rendered in a Hospital Emergency room will be payable at the in-network benefit level when rendered by either a non-preferred or Preferred Provider. The treatment must be for an Emergency as defined in the Plan. Follow-up care will be payable according to the Coverage Summary.

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
ACUPUNCTURE	The Plan covers Medically Necessary acupuncture for pain management.	\$20 Copay	80%
ALLERGY CARE -Office Visit -Treatment (Injections) -Serum -Laboratory & Scratch Testing		\$20 Copay 100% 100% \$20 Copay	80% 80% 80% 80%
AMBULANCE		100%	80%
ANESTHESIA -Inpatient -Outpatient -Office		100% 100% 100%	80% 80% 80%
BIOFEEDBACK		Not Covered	Not Covered
BLOOD AND BLOOD PRODUCTS		100%	80%
CARDIAC REHABILITATION -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHEMOTHERAPY -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHIROPRACTOR		First \$5000 paid at 100%, then next \$3400 paid at 50% per calendar year	80%
CONVALESCENT/SKILLED NURSING FACILITY	Maximum of 30 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.	100%	80%
DENTAL CARE COVERED UNDER MEDICAL PLAN -Accidental Injury to Teeth -Oral Surgery	Covered when Medically Necessary and not covered under Dental Plan.	100% 100%	80% First \$1,400 payable at 100%, after deductible; then 80%
DIABETIC TREATMENT -Education -Supplies and Equipment		\$20 Copay 100%	80% 80%

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DIAGNOSTIC X-RAYS AND IMAGING TESTS -Independent Facility -Outpatient Hospital -Physician's Office		\$20 Copay \$20 Copay \$20 Copay	First \$150 paid at 100% per calendar year; then 80% First \$150 paid at 100% per calendar year; then 80% First \$150 paid at 100% per calendar year; then 80%
HIGH TECH IMAGING (SUCH AS MRI, MRA, PET AND CAT SCANS)		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
DIALYSIS OR HEMODIALYSIS -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
DURABLE MEDICAL EQUIPMENT (DME) <i>Including, but not limited to:</i> -Disposable Medical Supplies -Prosthetics (External and Internal) -Wigs -Foot Orthotics -Orthotics (Braces) -Oxygen	 Covered when Medically Necessary. Under the age of 19 has no limit, but over age 19 is limited to one wig per Lifetime. Covered when Medically Necessary. Covered when Medically Necessary.	100% 100% \$20 Copay \$20 Copay \$20 Copay \$20 Copay 100%	80% 80% 80% 80% 80% 80% 80%
EATING DISORDERS		100%	80%
ENTERAL FORMULA	Covered if it is the patient's only source of nutrition. The Plan does not cover nutritional supplements.	100%	80%

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FAMILY PLANNING SERVICES			
-Elective Sterilization Procedures	Covered for Employee or spouse. Reversal is not covered.	Tubal Ligation = 100% Vasectomy = \$20 Copay	80%
-Voluntary Termination of Pregnancy	Covered for Employee, spouse, or Dependent.	\$20 Copay	80%
-Infertility Treatment	The Plan covers Medically Necessary diagnostic services and treatment of the Sickness or Injury that is the cause of infertility.	Not Covered	Not Covered
-Contraceptive Drugs and Devices	The Pharmacy Benefit Manager requires letter of Medical Necessity.	Covered under the Prescription Drug Plan	Covered under the Prescription Drug Plan
-Contraceptive Management Office Visit		Not Covered	Not Covered
-Early Intervention Services	The Plan covers learning disorders diagnosed as ADD, ADHD, Central Auditory Processing Disorders, Dyslexia, Dysgraphia, Dyscalculia, Dyspraxia, Apraxia or Hyperlexia.	\$20 Copay	80%
FOREIGN CARE			
-Emergent	Only covered for emergency situations.	100%	100%
-Non-Emergent	Current exchange rate applies.	Not Covered	80%
GENETIC TESTING	The Plan covers Genetic Testing, and associated counseling, when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature.	\$20 Copay	80%
GROWTH HORMONES	The Plan covers when Medically Necessary.	\$20 Copay	80%
HOME HEALTH CARE	Maximum of 60 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.		
-Aide, Nurse, or any other Authorized Agency Employee		100%	80%
-Home IV Therapy and Respiratory Care		100%	80%
HOSPICE CARE	For Covered Family Member diagnosed with a terminal illness and a life expectancy of six months or less.		
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-Home		100%	80%

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HOSPITAL FACILITY			
<u>Inpatient Hospital</u>	Maximum of 30 days for tuberculosis, contagious diseases and after effects of these conditions. Maximum of 30 days in all hospitals operated by a governmental body or agency, except when operated by a county or municipality.	100%	First 120 days paid at 100%; then \$5.00 per day for an additional 245 days in same benefit period with remaining charges paid at 80%
<u>Outpatient Hospital</u>			
-Emergency Room for a medical Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Emergency Room used for a Non-Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Outpatient Surgical Center		100%	80%
-Clinic		\$20 Copay	80%
INFUSION THERAPY	Includes chelation therapy.	100%	80%
LABORATORY			
-Independent Facility		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Outpatient Hospital		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Physician's Office		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
MASSAGE THERAPY (When rendered by a Licensed Massage Therapist)		Not Covered	Not Covered
MATERNITY CARE-MOTHER (Refer to Diagnostic X-rays, Imaging Tests and Laboratory for benefits related to maternity)			
-Inpatient Hospital	Pre-Certification is recommended if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section.	100%	100%; not subject to deductible
-Physician for Prenatal Care and Delivery		\$20 Copay	80%
-Birthing Center		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
MENTAL ILLNESS SERVICES	Coinsurance does not accrue toward the Out-of-Pocket Maximum. (Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Mental Illness admission.	100%	100% Maximum of 30 days per calendar year.
-Inpatient			
-Inpatient Physician		100%	80%
-Outpatient/Office	Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Substance Abuse Treatment.	\$20 Copay	80%
MODIFIED FOOD PRODUCT		Not Covered	Not Covered
NEWBORN CARE (Prior to Discharge)	When Plan covers both Mother and Baby Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Hospital			
-Physician		100%	80%
-Newborn Circumcision		100%	80%
NEWBORN CARE (Prior to Discharge)	When Plan covers the Baby but not the Mother Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Hospital			
-Physician		100%	80%
-Newborn Circumcision		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
NUTRITIONAL COUNSELING	Covered for Family Members with diabetes only.	\$20 Copay	80%
OBESITY TREATMENT	The Plan only covers charges for surgical procedures in cases of morbid obesity. The Plan does not cover charges for treatment of obesity, weight reduction, diet programs (Weight Watchers, Nutrisystem, etc.) or diet supplements.	100%	80%
OCCUPATIONAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%
ORGAN TRANSPLANTS	The Plan does not cover expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Medical Plan will be secondary. If an organ is sold, not donated, no benefits are paid for the donor's expenses.	100%	80%
PHYSICAL REHABILITATION FACILITY		100%	80%
PHYSICAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PHYSICIAN			
-Inpatient		100%	First \$8.00 per day, up to a \$960 maximum, paid at 100%; then 80%
-Office		\$20 Copay	80%
-Home		\$20 Copay	80%
<u>Consultation (Specialist)</u>			
-Inpatient		100%	80%
-Outpatient		\$20 Copay	80%
-Office		\$20 Copay	80%
<u>Second Medical Opinion</u>		\$20 Copay	80%
PREADMISSION TESTING		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
PREVENTATIVE/WELL CARE			
-Bone Density Testing		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Colonoscopy/Sigmoidoscopy		100%	80%
-GYN Office Visit	Maximum of 2 visits per calendar year.	\$20 Copay	80%
-Mammogram	Maximum of 1 per calendar year, unless Medical Necessity.	\$20 Copay	80%
-PAP Smear	Maximum of 2 per calendar year.	\$20 Copay When performed during GYN Office Visit an additional Copay will not be taken.	80%
-Prostate Cancer Screening (PSA)	Maximum of 2 per calendar year.	\$20 Copay	80%
-Routine Adult Physical	Maximum of 1 per calendar year. (includes appropriate labs and x-rays)	\$20 Copay	80%
	The Plan does not cover immunizations, HPV vaccine, and Flu vaccinations.		
-Well Child Care	Up to and including age 12. (includes appropriate labs, x-rays and immunizations)	\$20 Copay	80%
-Hearing Exams		\$20 Copay	80%
-Hearing Aids		\$20 Copay	80%
-Eye Exams		Not Covered	Not Covered
-Frames and Lenses		Not Covered	Not Covered

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PRIVATE DUTY NURSING		Not Covered	Not Covered
RADIATION THERAPY -Outpatient Hospital -Any other place of service		100% 100%	First \$320 paid at 100% per calendar year; then 80% First \$320 paid at 100% per calendar year; then 80%
RESPIRATORY THERAPY -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
SLEEP DISORDERS	The Plan only covers sleep studies and apnea monitors.	\$20 Copay	80%
SMOKING CESSATION PRODUCTS		Not Covered	Not Covered
SPEECH THERAPY -Outpatient Hospital -Any other place of service		100% 100%	First \$50 paid at 100% per incident; then 80% First \$50 paid at 100% per incident; then 80%
SUBSTANCE ABUSE TREATMENT -Detoxification -Inpatient Rehabilitation -Inpatient Physician -Outpatient/Office	Coinsurance does not accrue toward the Out-of-Pocket Maximum. (Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Substance Abuse admission. Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Mental Illness Services.	Included in Inpatient Rehabilitation 100% 100% \$20 Copay	Included in Inpatient Rehabilitation 100% Maximum of 30 days per calendar year. 80% 80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery) <u>Surgeon</u> -Inpatient -Outpatient -Office <u>Assistant Surgeon</u> <u>Second Surgical Opinion</u> -Voluntary -Mandatory	Maximum of 20% of the Surgeon's fee.	100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	80%
		\$20 Copay Not Required	80% Not Required

Out-of-Network Surgical Allowance Schedule

Appendectomy	\$280
Breast, removal of benign tumor	\$105
Fracture of femur, neck, intertrochanteric, simple or compound, open reduction	\$560
Fracture of radius and ulna, simple closed reduction	\$175
Gall bladder, removal of	\$420
Heart, removal of intra cardiac tumor	\$210
Hemorrhoidectomy, internal and external	
Herniotomy, inguinal (single)	\$245
Hip, fusion of	\$700
Hysterectomy, total corpus and cervix	\$420
Mastoidectomy, modified radical or radical without skin graft	\$560
Prostatectomy, suprapubic, one or two stages	\$560
Spine and Spinal Cord, laminotomy for removal of intervertebral discs, lumbar	\$630
Stomach, partial removal of	\$630
Tonsils and Adenoids, removal of	
Under age 18	\$105
18 years or over	\$140

- Above surgeries payable at 100% of allowance, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.
- For surgeries not listed in this schedule, maximum allowance is \$1,400 payable at 100%, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.

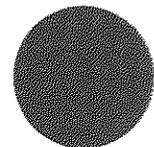
		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY CENTER (Freestanding Surgical Facility)		100%	80%
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)	The Plan only covers diagnostic x-rays and testing. Any treatment, including surgery, is not covered.	\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
URGENT CARE FACILITY		100%	80%

PREScription DRUG EXPENSE BENEFIT

TYPE OF PROGRAM	IMPORTANT PROVISIONS	IN-NETWORK PHARMACY BENEFIT
RETAIL DRUGS	Copay is for each separate prescription or refill.	\$10.00 Copay – Generic Drug \$20.00 Copay – Brand Name Drug
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply. Copay is for each separate prescription or refill.	\$10.00 Copay – Generic Drug \$20.00 Copay – Brand Name Drug
DIABETIC SUPPLIES AND EQUIPMENT	Diabetic supplies and equipment that are covered as a Medical Expense Benefit will not be covered as a Prescription Drug Expense Benefit.	See benefit for Retail and Mail Order Maintenance Drugs.
<p>Copays under the Prescription Drug Expense Benefit do not count toward the Medical Out-of-Pocket Maximum. The Medical Expense Benefit portion of the Plan covers prescription drugs purchased from an Out-of-Network Pharmacy payable at 80%; subject to the Medical Deductible. Copays are not covered.</p>		
<p>Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.</p>		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

MEDICAL COVERAGE SUMMARY INDEMNITY PLAN



**APPLIES TO: ACTIVE SUPERIOR POLICEMEN, COBRA BENEFICIARIES,
AND THEIR DEPENDENTS
EFFECTIVE JANUARY 1, 2015**

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
DEDUCTIBLE	Per calendar year. (Carryover does not apply) Applies only to major medical benefits.	None	\$100 Individual \$200 Family
OUT-OF-POCKET MAXIMUM	Per calendar year. Includes the calendar year deductible and Coinsurance amounts. Does not include Copayments, prescription drug Copayments, amounts in excess of the Reasonable and Customary, amounts in excess of the Plan maximums, any charges for services which are not covered, and charges for Mental Illness and Substance Abuse, including treatment of alcoholism. Applies only to major medical benefits.	None	\$500 Individual \$1,000 Family
LIFETIME MAXIMUM	Applies only to non-essential, major medical benefits.	No Limit	\$1,000,000

Radiologist, Anesthesiologists, Pathologists and Emergency Care: If you have a covered surgical procedure or inpatient stay when attended and admitted by a Preferred Provider, services by the associated radiologist, anesthesiologist or pathologist, will be payable at the in-network benefit level. Emergency care and associated professional fees (anesthesiologist, pathologist, radiologist) rendered in a Hospital Emergency room will be payable at the in-network benefit level when rendered by either a non-preferred or Preferred Provider. The treatment must be for an Emergency as defined in the Plan. Follow-up care will be payable according to the Coverage Summary.

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
ACUPUNCTURE	The Plan covers Medically Necessary acupuncture for pain management.	\$20 Copay	80%
ALLERGY CARE -Office Visit -Treatment (Injections) -Serum -Laboratory & Scratch Testing		\$20 Copay 100% 100% \$20 Copay	80% 80% 80% 80%
AMBULANCE		100%	80%
ANESTHESIA -Inpatient -Outpatient -Office		100% 100% 100%	80% 80% 80%
BIOFEEDBACK		Not Covered	Not Covered
BLOOD AND BLOOD PRODUCTS		100%	80%
CARDIAC REHABILITATION -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHEMOTHERAPY -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHIROPRACTOR		First \$5000 paid at 100%, then next \$3400 paid at 50% per calendar year	80%
CONVALESCENT/SKILLED NURSING FACILITY	Maximum of 30 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.	100%	80%
DENTAL CARE COVERED UNDER MEDICAL PLAN -Accidental Injury to Teeth -Oral Surgery	Covered when Medically Necessary and not covered under Dental Plan.	100% 100%	80% First \$1,400 payable at 100%, after deductible; then 80%
DIABETIC TREATMENT -Education -Supplies and Equipment		\$20 Copay 100%	80% 80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
FAMILY PLANNING SERVICES			
-Elective Sterilization Procedures	Covered for Employee or spouse. Reversal is not covered.	Tubal Ligation = 100% Vasectomy = \$20 Copay	80%
-Voluntary Termination of Pregnancy	Covered for Employee, spouse, or Dependent.	\$20 Copay	80%
-Infertility Treatment	The Plan covers Medically Necessary diagnostic services and treatment of the Sickness or Injury that is the cause of infertility.	Not Covered	Not Covered
-Contraceptive Drugs and Devices	The Pharmacy Benefit Manager requires letter of Medical Necessity.	Covered under the Prescription Drug Plan	Covered under the Prescription Drug Plan
-Contraceptive Management Office Visit		Not Covered	Not Covered
-Early Intervention Services	The Plan covers learning disorders diagnosed as ADD, ADHD, Central Auditory Processing Disorders, Dyslexia, Dysgraphia, Dyscalculia, Dyspraxia, Apraxia or Hyperlexia.	\$20 Copay	80%
FOREIGN CARE			
-Emergent	Only covered for emergency situations.	100%	100%
-Non-Emergent	Current exchange rate applies.	Not Covered	80%
GENETIC TESTING	The Plan covers Genetic Testing, and associated counseling, when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature.	\$20 Copay	80%
GROWTH HORMONES	The Plan covers when Medically Necessary.	\$20 Copay	80%
HOME HEALTH CARE	Maximum of 60 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.		
-Aide, Nurse, or any other Authorized Agency Employee		100%	80%
-Home IV Therapy and Respiratory Care		100%	80%
HOSPICE CARE	For Covered Family Member diagnosed with a terminal illness and a life expectancy of six months or less.		
-Inpatient		100%	80%
-Home		100%	80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
HOSPITAL FACILITY			
<u>Inpatient Hospital</u>	Maximum of 30 days for tuberculosis, contagious diseases and after effects of these conditions. Maximum of 30 days in all hospitals operated by a governmental body or agency, except when operated by a county or municipality.	100%	First 120 days paid at 100%; then \$5.00 per day for an additional 245 days in same benefit period with remaining charges paid at 80%
<u>Outpatient Hospital</u>			
-Emergency Room for a medical Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Emergency Room used for a Non-Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Outpatient Surgical Center		100%	80%
-Clinic		\$20 Copay	80%
INFUSION THERAPY	Includes chelation therapy.	100%	80%
LABORATORY			
-Independent Facility		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Outpatient Hospital		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Physician's Office		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
MASSAGE THERAPY (When rendered by a Licensed Massage Therapist)		Not Covered	Not Covered
MATERNITY CARE-MOTHER (Refer to Diagnostic X-rays, Imaging Tests and Laboratory for benefits related to maternity)			
-Inpatient Hospital	Pre-Certification is recommended if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section.	100%	100%; not subject to deductible
-Physician for Prenatal Care and Delivery		\$20 Copay	80%
-Birthing Center		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
MENTAL ILLNESS SERVICES	Coinsurance does not accrue toward the Out-of-Pocket Maximum. (Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Mental Illness admission.	100%	100% Maximum of 30 days per calendar year.
-Inpatient			
-Inpatient Physician		100%	80%
-Outpatient/Office	Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Substance Abuse Treatment.	\$20 Copay	80%
MODIFIED FOOD PRODUCT		Not Covered	Not Covered
NEWBORN CARE (Prior to Discharge)	When Plan covers both Mother and Baby		
-Hospital	Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Physician		100%	80%
-Newborn Circumcision		100%	80%
NEWBORN CARE (Prior to Discharge)	When Plan covers the Baby but not the Mother		
-Hospital	Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Physician		100%	80%
-Newborn Circumcision		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
NUTRITIONAL COUNSELING	Covered for Family Members with diabetes only.	\$20 Copay	80%
OBESITY TREATMENT	The Plan only covers charges for surgical procedures in cases of morbid obesity. The Plan does not cover charges for treatment of obesity, weight reduction, diet programs (Weight Watchers, Nutrisystem, etc.) or diet supplements.	100%	80%
OCCUPATIONAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%
ORGAN TRANSPLANTS	The Plan does not cover expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Medical Plan will be secondary. If an organ is sold, not donated, no benefits are paid for the donor's expenses.	100%	80%
PHYSICAL REHABILITATION FACILITY		100%	80%
PHYSICAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%

The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.

The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PHYSICIAN -Inpatient -Office -Home <u>Consultation (Specialist)</u> -Inpatient -Outpatient -Office <u>Second Medical Opinion</u>		100% \$20 Copay \$20 Copay 100% \$20 Copay \$20 Copay \$20 Copay	First \$8.00 per day, up to a \$960 maximum, paid at 100%; then 80% 80% 80% 80% 80% 80% 80%
PREADMISSION TESTING		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
PREVENTATIVE/WELL CARE -Bone Density Testing -Colonoscopy/Sigmoidoscopy -GYN Office Visit -Mammogram -PAP Smear -Prostate Cancer Screening (PSA) -Routine Adult Physical -Well Child Care -Hearing Exams -Hearing Aids -Eye Exams -Frames and Lenses	Maximum of 2 visits per calendar year. Maximum of 1 per calendar year, unless Medical Necessity. Maximum of 2 per calendar year. Maximum of 2 per calendar year. Maximum of 1 per calendar year. (includes appropriate labs and x-rays) The Plan does not cover immunizations, HPV vaccine, and Flu vaccinations. Up to and including age 12. (includes appropriate labs, x-rays and immunizations)	\$20 Copay 100% \$20 Copay \$20 Copay \$20 Copay When performed during GYN Office Visit an additional Copay will not be taken. \$20 Copay \$20 Copay \$20 Copay \$20 Copay Not Covered Not Covered	First \$150 paid at 100% per calendar year; then 80% 80% 80% 80% 80% 80% 80% Not Covered Not Covered

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PRIVATE DUTY NURSING		Not Covered	Not Covered
RADIATION THERAPY -Outpatient Hospital -Any other place of service		100% 100%	First \$320 paid at 100% per calendar year; then 80% First \$320 paid at 100% per calendar year; then 80%
RESPIRATORY THERAPY -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
SLEEP DISORDERS	The Plan only covers sleep studies and apnea monitors.	\$20 Copay	80%
SMOKING CESSATION PRODUCTS		Not Covered	Not Covered
SPEECH THERAPY -Outpatient Hospital -Any other place of service		100% 100%	First \$50 paid at 100% per incident; then 80% First \$50 paid at 100% per incident; then 80%
SUBSTANCE ABUSE TREATMENT -Detoxification -Inpatient Rehabilitation -Inpatient Physician -Outpatient/Office	Coinsurance does not accrue toward the Out-of-Pocket Maximum. (Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Substance Abuse admission. Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Mental Illness Services.	Included in Inpatient Rehabilitation 100% 100% \$20 Copay	Included in Inpatient Rehabilitation 100% Maximum of 30 days per calendar year. 80% 80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery)			
<u>Surgeon</u> -Inpatient		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
-Outpatient		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
-Office		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
<u>Assistant Surgeon</u>	Maximum of 20% of the Surgeon's fee.	100%	80%
<u>Second Surgical Opinion</u> -Voluntary -Mandatory		\$20 Copay Not Required	80% Not Required

Out-of-Network Surgical Allowance Schedule

Appendectomy	\$280
Breast, removal of benign tumor	\$105
Fracture of femur, neck, intertrochanteric, simple or compound, open reduction	\$560
Fracture of radius and ulna, simple closed reduction	\$175
Gall bladder, removal of	\$420
Heart, removal of intra cardiac tumor	\$210
Hemorrhoidectomy, internal and external	
Herniotomy, inguinal (single)	\$245
Hip, fusion of	\$700
Hysterectomy, total corpus and cervix	\$420
Mastoidectomy, modified radical or radical without skin graft	\$560
Prostatectomy, suprapubic, one or two stages	\$560
Spine and Spinal Cord, laminotomy for removal of intervertebral discs, lumbar	\$630
Stomach, partial removal of	\$630
Tonsils and Adenoids, removal of	
Under age 18	\$105
18 years or over	\$140

- Above surgeries payable at 100% of allowance, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.
- For surgeries not listed in this schedule, maximum allowance is \$1,400 payable at 100%, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY CENTER (Freestanding Surgical Facility)		100%	80%
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)	The Plan only covers diagnostic x-rays and testing. Any treatment, including surgery, is not covered.	\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
URGENT CARE FACILITY		100%	80%

PRESCRIPTION DRUG EXPENSE BENEFIT

TYPE OF PROGRAM	IMPORTANT PROVISIONS	IN-NETWORK PHARMACY BENEFIT
RETAIL DRUGS	Copay is for each separate prescription or refill.	\$10.00 Copay – Generic Drug \$20.00 Copay – Brand Name Drug
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply. Copay is for each separate prescription or refill.	\$10.00 Copay – Generic Drug \$20.00 Copay – Brand Name Drug
DIABETIC SUPPLIES AND EQUIPMENT	Diabetic supplies and equipment that are covered as a Medical Expense Benefit will not be covered as a Prescription Drug Expense Benefit.	See benefit for Retail and Mail Order Maintenance Drugs.
<p style="text-align: center;">Copays under the Prescription Drug Expense Benefit do not count toward the Medical Out-of-Pocket Maximum. The Medical Expense Benefit portion of the Plan covers prescription drugs purchased from an Out-of-Network Pharmacy payable at 80%; subject to the Medical Deductible. Copays are not covered.</p>		
<p style="text-align: center;">Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.</p>		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

MEDICAL COVERAGE SUMMARY INDEMNITY PLAN



**APPLIES TO: ACTIVE FIREMEN, COBRA BENEFICIARIES, AND THEIR DEPENDENTS
EFFECTIVE JANUARY 1, 2015**

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
DEDUCTIBLE	Per calendar year. (Carryover does not apply) Applies only to major medical benefits.	None	\$200 Individual \$400 Family
OUT-OF-POCKET MAXIMUM	Per calendar year. Includes the calendar year deductible and Coinsurance amounts. Does not include Copayments, prescription drug Copayments, amounts in excess of the Reasonable and Customary, amounts in excess of the Plan maximums, any charges for services which are not covered, and charges for Mental Illness and Substance Abuse, including treatment of alcoholism. Applies only to major medical benefits.	None	\$500 Individual \$1,000 Family
LIFETIME MAXIMUM	Applies only to non-essential, major medical benefits.	No Limit	\$1,000,000
<p><u>Radiologist, Anesthesiologists, Pathologists and Emergency Care:</u> If you have a covered surgical procedure or inpatient stay when attended and admitted by a Preferred Provider, services by the associated radiologist, anesthesiologist or pathologist, will be payable at the in-network benefit level. Emergency care and associated professional fees (anesthesiologist, pathologist, radiologist) rendered in a Hospital Emergency room will be payable at the in-network benefit level when rendered by either a non-preferred or Preferred Provider. The treatment must be for an Emergency as defined in the Plan. Follow-up care will be payable according to the Coverage Summary.</p>			

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
ACUPUNCTURE	The Plan covers Medically Necessary acupuncture for pain management.	\$20 Copay	80%
ALLERGY CARE -Office Visit -Treatment (Injections) -Serum -Laboratory & Scratch Testing		\$20 Copay 100% 100% \$20 Copay	80% 80% 80% 80%
AMBULANCE		100%	80%
ANESTHESIA -Inpatient -Outpatient -Office		100% 100% 100%	80% 80% 80%
BIOFEEDBACK		Not Covered	Not Covered
BLOOD AND BLOOD PRODUCTS		100%	80%
CARDIAC REHABILITATION -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHEMOTHERAPY -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHIROPRACTOR		First \$5000 paid at 100%, then next \$3400 paid at 50% per calendar year	80%
CONVALESCENT/SKILLED NURSING FACILITY	Maximum of 30 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.	100%	80%
DENTAL CARE COVERED UNDER MEDICAL PLAN -Accidental Injury to Teeth -Oral Surgery	Covered when Medically Necessary and not covered under Dental Plan.	100% 100%	80% First \$1,400 payable at 100%, after deductible; then 80%
DIABETIC TREATMENT -Education -Supplies and Equipment		\$20 Copay 100%	80% 80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
DIAGNOSTIC X-RAYS AND IMAGING TESTS -Independent Facility -Outpatient Hospital -Physician's Office		\$20 Copay \$20 Copay \$20 Copay	First \$150 paid at 100% per calendar year; then 80% First \$150 paid at 100% per calendar year; then 80% First \$150 paid at 100% per calendar year; then 80%
HIGH TECH IMAGING (SUCH AS MRI, MRA, PET AND CAT SCANS)		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
DIALYSIS OR HEMODIALYSIS -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
DURABLE MEDICAL EQUIPMENT (DME) <i>Including, but not limited to:</i> -Disposable Medical Supplies -Prosthetics (External and Internal) -Wigs -Foot Orthotics -Orthotics (Braces) -Oxygen	 Covered when Medically Necessary. Under the age of 19 has no limit, but over age 19 is limited to one wig per Lifetime. Covered when Medically Necessary. Covered when Medically Necessary.	100% 100% \$20 Copay \$20 Copay \$20 Copay \$20 Copay 100%	80% 80% 80% 80% 80% 80% 80%
EATING DISORDERS		100%	80%
ENTERAL FORMULA	Covered if it is the patient's only source of nutrition. The Plan does not cover nutritional supplements.	100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
FAMILY PLANNING SERVICES			
-Elective Sterilization Procedures	Covered for Employee or spouse. Reversal is not covered.	Tubal Ligation = 100% Vasectomy = \$20 Copay	80%
-Voluntary Termination of Pregnancy	Covered for Employee, spouse, or Dependent.	\$20 Copay	80%
-Infertility Treatment	The Plan covers Medically Necessary diagnostic services and treatment of the Sickness or Injury that is the cause of infertility.	Not Covered	Not Covered
-Contraceptive Drugs and Devices	The Pharmacy Benefit Manager requires letter of Medical Necessity.	Covered under the Prescription Drug Plan	Covered under the Prescription Drug Plan
-Contraceptive Management Office Visit		Not Covered	Not Covered
-Early Intervention Services	The Plan covers learning disorders diagnosed as ADD, ADHD, Central Auditory Processing Disorders, Dyslexia, Dysgraphia, Dyscalculia, Dyspraxia, Apraxia or Hyperlexia.	\$20 Copay	80%
FOREIGN CARE			
-Emergent	Only covered for emergency situations.	100%	100%
-Non-Emergent	Current exchange rate applies.	Not Covered	80%
GENETIC TESTING	The Plan covers Genetic Testing, and associated counseling, when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature.	\$20 Copay	80%
GROWTH HORMONES	The Plan covers when Medically Necessary.	\$20 Copay	80%
HOME HEALTH CARE	Maximum of 60 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.		
-Aide, Nurse, or any other Authorized Agency Employee		100%	80%
-Home IV Therapy and Respiratory Care		100%	80%
HOSPICE CARE	For Covered Family Member diagnosed with a terminal illness and a life expectancy of six months or less.		
-Inpatient		100%	80%
-Home		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
HOSPITAL FACILITY			
<u>Inpatient Hospital</u>	Maximum of 30 days for tuberculosis, contagious diseases and after effects of these conditions. Maximum of 30 days in all hospitals operated by a governmental body or agency, except when operated by a county or municipality.	100%	First 120 days paid at 100%; then \$5.00 per day for an additional 245 days in same benefit period with remaining charges paid at 80%
<u>Outpatient Hospital</u>			
-Emergency Room for a medical Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Emergency Room used for a Non-Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Outpatient Surgical Center		100%	80%
-Clinic		\$20 Copay	80%
INFUSION THERAPY	Includes chelation therapy.	100%	80%
LABORATORY			
-Independent Facility		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Outpatient Hospital		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Physician's Office		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
MASSAGE THERAPY (When rendered by a Licensed Massage Therapist)		Not Covered	Not Covered
MATERNITY CARE-MOTHER (Refer to Diagnostic X-rays, Imaging Tests and Laboratory for benefits related to maternity)			
-Inpatient Hospital	Pre-Certification is recommended if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section.	100%	100%; not subject to deductible
-Physician for Prenatal Care and Delivery		\$20 Copay	80%
-Birthing Center		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
MENTAL ILLNESS SERVICES			
-Inpatient	Coinsurance does not accrue toward the Out-of-Pocket Maximum. (Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Mental Illness admission.	100%	100% Maximum of 30 days per calendar year.
-Inpatient Physician		100%	80%
-Outpatient/Office	Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Substance Abuse Treatment.	\$20 Copay	80%
MODIFIED FOOD PRODUCT		Not Covered	Not Covered
NEWBORN CARE (Prior to Discharge)	When Plan covers both Mother and Baby		
-Hospital	Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Physician		100%	80%
-Newborn Circumcision		100%	80%
NEWBORN CARE (Prior to Discharge)	When Plan covers the Baby but not the Mother		
-Hospital	Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Physician		100%	80%
-Newborn Circumcision		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
NUTRITIONAL COUNSELING	Covered for Family Members with diabetes only.	\$20 Copay	80%
OBESITY TREATMENT	The Plan only covers charges for surgical procedures in cases of morbid obesity. The Plan does not cover charges for treatment of obesity, weight reduction, diet programs (Weight Watchers, Nutrisystem, etc.) or diet supplements.	100%	80%
OCCUPATIONAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%
ORGAN TRANSPLANTS	The Plan does not cover expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Medical Plan will be secondary. If an organ is sold, not donated, no benefits are paid for the donor's expenses.	100%	80%
PHYSICAL REHABILITATION FACILITY		100%	80%
PHYSICAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PHYSICIAN			
-Inpatient		100%	First \$8.00 per day, up to a \$960 maximum, paid at 100%; then 80%
-Office		\$20 Copay	80%
-Home		\$20 Copay	80%
<u>Consultation (Specialist)</u>			
-Inpatient		100%	80%
-Outpatient		\$20 Copay	80%
-Office		\$20 Copay	80%
<u>Second Medical Opinion</u>		\$20 Copay	80%
PREADMISSION TESTING		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
PREVENTATIVE/WELL CARE			
-Bone Density Testing		\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
-Colonoscopy/Sigmoidoscopy		100%	80%
-GYN Office Visit	Maximum of 2 visits per calendar year.	\$20 Copay	80%
-Mammogram	Maximum of 1 per calendar year, unless Medical Necessity.	\$20 Copay	80%
-PAP Smear	Maximum of 2 per calendar year.	\$20 Copay When performed during GYN Office Visit an additional Copay will not be taken.	80%
-Prostate Cancer Screening (PSA)	Maximum of 2 per calendar year.	\$20 Copay	80%
-Routine Adult Physical	Maximum of 1 per calendar year. (includes appropriate labs and x-rays)	\$20 Copay	80%
-Well Child Care	The Plan does not cover immunizations, HPV vaccine, and Flu vaccinations. Up to and including age 12. (Includes appropriate labs and x-rays. Immunizations covered to age 23.)	\$20 Copay	80%
-Hearing Exams		\$20 Copay	80%
-Hearing Aids		\$20 Copay	80%
-Eye Exams		Not Covered	Not Covered
-Frames and Lenses		Not Covered	Not Covered

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PRIVATE DUTY NURSING		Not Covered	Not Covered
RADIATION THERAPY -Outpatient Hospital -Any other place of service		100% 100%	First \$320 paid at 100% per calendar year; then 80% First \$320 paid at 100% per calendar year; then 80%
RESPIRATORY THERAPY -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
SLEEP DISORDERS	The Plan only covers sleep studies and apnea monitors.	\$20 Copay	80%
SMOKING CESSATION PRODUCTS		Not Covered	Not Covered
SPEECH THERAPY -Outpatient Hospital -Any other place of service		100% 100%	First \$50 paid at 100% per incident; then 80% First \$50 paid at 100% per incident; then 80%
SUBSTANCE ABUSE TREATMENT -Detoxification -Inpatient Rehabilitation -Inpatient Physician -Outpatient/Office	Coinsurance does not accrue toward the Out-of-Pocket Maximum. (Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Substance Abuse admission. Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Mental Illness Services.	Included in Inpatient Rehabilitation 100% 100% \$20 Copay	Included in Inpatient Rehabilitation 100% Maximum of 30 days per calendar year. 80% 80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery) <u>Surgeon</u> -Inpatient -Outpatient -Office <u>Assistant Surgeon</u> <u>Second Surgical Opinion</u> -Voluntary -Mandatory	Maximum of 20% of the Surgeon's fee.	100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
		100%	80%
		\$20 Copay Not Required	80% Not Required

Out-of-Network Surgical Allowance Schedule

Appendectomy	\$280
Breast, removal of benign tumor	\$105
Fracture of femur, neck, intertrochanteric, simple or compound, open reduction	\$560
Fracture of radius and ulna, simple closed reduction	\$175
Gall bladder, removal of	\$420
Heart, removal of intra cardiac tumor	\$210
Hemorrhoidectomy, internal and external	
Herniotomy, inguinal (single)	\$245
Hip, fusion of	\$700
Hysterectomy, total corpus and cervix	\$420
Mastoidectomy, modified radical or radical without skin graft	\$560
Prostatectomy, suprapubic, one or two stages	\$560
Spine and Spinal Cord, laminotomy for removal of intervertebral discs, lumbar	\$630
Stomach, partial removal of	\$630
Tonsils and Adenoids, removal of	
Under age 18	\$105
18 years or over	\$140

- Above surgeries payable at 100% of allowance, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.
- For surgeries not listed in this schedule, maximum allowance is \$1,400 payable at 100%, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.

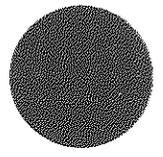
		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY CENTER (Freestanding Surgical Facility)		100%	80%
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)	The Plan only covers diagnostic x-rays and testing. Any treatment, including surgery, is not covered.	\$20 Copay	First \$150 paid at 100% per calendar year; then 80%
URGENT CARE FACILITY		100%	80%

PREScription DRUG EXPENSE BENEFIT

TYPE OF PROGRAM	IMPORTANT PROVISIONS	IN-NETWORK PHARMACY BENEFIT
RETAIL DRUGS	Copay is for each separate prescription or refill.	\$10.00 Copay – Generic Drug \$20.00 Copay – Brand Name Drug
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply. Copay is for each separate prescription or refill.	\$10.00 Copay – Generic Drug \$20.00 Copay – Brand Name Drug
DIABETIC SUPPLIES AND EQUIPMENT	Diabetic supplies and equipment that are covered as a Medical Expense Benefit will not be covered as a Prescription Drug Expense Benefit.	See benefit for Retail and Mail Order Maintenance Drugs.
<p>Maximum of \$1,100 on family prescription Copays. The combination of Family Members' Copays has to reach \$1,100; then there will be no Copay from that point on for the rest of that calendar year.</p> <p>Copays under the Prescription Drug Expense Benefit do not count toward the Medical Out-of-Pocket Maximum.</p> <p>The Medical Expense Benefit portion of the Plan covers prescription drugs purchased from an Out-of-Network Pharmacy payable at 80%; subject to the Medical Deductible. Copays are not covered.</p>		
<p>Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.</p>		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

MEDICAL COVERAGE SUMMARY INDEMNITY PLAN



**APPLIES TO: ACTIVE SCHOOL CROSSING GUARDS, COBRA BENEFICIARIES,
AND THEIR DEPENDENTS
EFFECTIVE JANUARY 1, 2015**

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
DEDUCTIBLE	Per calendar year. (Carryover does not apply) Applies only to major medical benefits.	None	\$100 Individual \$200 Family
OUT-OF-POCKET MAXIMUM	Per calendar year. Includes the calendar year deductible and Coinsurance amounts. Does not include Copayments, prescription drug Copayments, amounts in excess of the Reasonable and Customary, amounts in excess of the Plan maximums, any charges for services which are not covered, and charges for Mental Illness and Substance Abuse, including treatment of alcoholism. Applies only to major medical benefits.	None	\$500 Individual \$1,000 Family
LIFETIME MAXIMUM	Applies only to non-essential, major medical benefits.	No Limit	\$1,000,000

Radiologist, Anesthesiologists, Pathologists and Emergency Care: If you have a covered surgical procedure or inpatient stay when attended and admitted by a Preferred Provider, services by the associated radiologist, anesthesiologist or pathologist, will be payable at the in-network benefit level. Emergency care and associated professional fees (anesthesiologist, pathologist, radiologist) rendered in a Hospital Emergency room will be payable at the in-network benefit level when rendered by either a non-preferred or Preferred Provider. The treatment must be for an Emergency as defined in the Plan. Follow-up care will be payable according to the Coverage Summary.

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
ACUPUNCTURE	The Plan covers Medically Necessary acupuncture for pain management.	\$10 Copay	80%
ALLERGY CARE -Office Visit -Treatment (Injections) -Serum -Laboratory & Scratch Testing		\$10 Copay 100% 100% \$10 Copay	80% 80% 80% 80%
AMBULANCE		100%	80%
ANESTHESIA -Inpatient -Outpatient -Office		100% 100% 100%	80% 80% 80%
BIOFEEDBACK		Not Covered	Not Covered
BLOOD AND BLOOD PRODUCTS		100%	80%
CARDIAC REHABILITATION -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHEMOTHERAPY -Outpatient Hospital -Any other place of service		100% 100%	80% 80%
CHIROPRACTOR		First \$5000 paid at 100%, then next \$3400 paid at 50% per calendar year	80%
CONVALESCENT/SKILLED NURSING FACILITY	Maximum of 30 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.	100%	80%
DENTAL CARE COVERED UNDER MEDICAL PLAN -Accidental Injury to Teeth -Oral Surgery	Covered when Medically Necessary and not covered under Dental Plan.	100% 100%	80% First \$1,400 payable at 100%, after deductible; then 80%
DIABETIC TREATMENT -Education -Supplies and Equipment		\$10 Copay 100%	80% 80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
FAMILY PLANNING SERVICES			
-Elective Sterilization Procedures	Covered for Employee or spouse. Reversal is not covered.	Tubal Ligation = 100% Vasectomy = \$10 Copay	80%
-Voluntary Termination of Pregnancy	Covered for Employee, spouse, or Dependent.	\$10 Copay	80%
-Infertility Treatment	The Plan covers Medically Necessary diagnostic services and treatment of the Sickness or Injury that is the cause of infertility.	Not Covered	Not Covered
-Contraceptive Drugs and Devices	The Pharmacy Benefit Manager requires letter of Medical Necessity.	Covered under the Prescription Drug Plan	Covered under the Prescription Drug Plan
-Contraceptive Management Office Visit		Not Covered	Not Covered
-Early Intervention Services	The Plan covers learning disorders diagnosed as ADD, ADHD, Central Auditory Processing Disorders, Dyslexia, Dysgraphia, Dyscalculia, Dyspraxia, Apraxia or Hyperlexia.	\$10 Copay	80%
FOREIGN CARE			
-Emergent	Only covered for emergency situations.	100%	100%
-Non-Emergent	Current exchange rate applies.	Not Covered	80%
GENETIC TESTING	The Plan covers Genetic Testing, and associated counseling, when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature.	\$10 Copay	80%
GROWTH HORMONES	The Plan covers when Medically Necessary.	\$10 Copay	80%
HOME HEALTH CARE	Maximum of 60 visits per calendar year. Maximums are combined for In and Out-of-Network Providers.		
-Aide, Nurse, or any other Authorized Agency Employee		100%	80%
-Home IV Therapy and Respiratory Care		100%	80%
HOSPICE CARE	For Covered Family Member diagnosed with a terminal illness and a life expectancy of six months or less.		
-Inpatient		100%	80%
-Home		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
HOSPITAL FACILITY <u>Inpatient Hospital</u>	Maximum of 30 days for tuberculosis, contagious diseases and after effects of these conditions. Maximum of 30 days in all hospitals operated by a governmental body or agency, except when operated by a county or municipality.	100%	First 120 days paid at 100%; then \$5.00 per day for an additional 245 days in same benefit period with remaining charges paid at 80%
<u>Outpatient Hospital</u>			
-Emergency Room for a medical Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Emergency Room used for a Non-Emergency	Includes ER Physician.	100%	100%; not subject to deductible
-Outpatient Surgical Center		100%	80%
-Clinic		\$10 Copay	80%
INFUSION THERAPY	Includes chelation therapy.	100%	80%
LABORATORY			
-Independent Facility		\$10 Copay	First \$150 paid at 100% per calendar year; then 80%
-Outpatient Hospital		\$10 Copay	First \$150 paid at 100% per calendar year; then 80%
-Physician's Office		\$10 Copay	First \$150 paid at 100% per calendar year; then 80%
MASSAGE THERAPY (When rendered by a Licensed Massage Therapist)		Not Covered	Not Covered
MATERNITY CARE-MOTHER (Refer to Diagnostic X-rays, Imaging Tests and Laboratory for benefits related to maternity)			
-Inpatient Hospital	Pre-Certification is recommended if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section.	100%	100%; not subject to deductible
-Physician for Prenatal Care and Delivery		\$10 Copay	80%
-Birthing Center		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
MENTAL ILLNESS SERVICES	Coinsurance does not accrue toward the Out-of-Pocket Maximum. (Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Mental Illness admission.	100%	100% Maximum of 30 days per calendar year.
-Inpatient			
-Inpatient Physician		100%	80%
-Outpatient/Office	Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Substance Abuse Treatment.	\$10 Copay	80%
MODIFIED FOOD PRODUCT		Not Covered	Not Covered
NEWBORN CARE (Prior to Discharge)	When Plan covers both Mother and Baby Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Hospital			
-Physician		100%	80%
-Newborn Circumcision		100%	80%
NEWBORN CARE (Prior to Discharge)	When Plan covers the Baby but not the Mother Pre-Certification is recommended if the newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.	100%	100%; not subject to deductible
-Hospital			
-Physician		100%	80%
-Newborn Circumcision		100%	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
NUTRITIONAL COUNSELING	Covered for Family Members with diabetes only.	\$10 Copay	80%
OBESITY TREATMENT	The Plan only covers charges for surgical procedures in cases of morbid obesity. The Plan does not cover charges for treatment of obesity, weight reduction, diet programs (Weight Watchers, Nutrisystem, etc.) or diet supplements.	100%	80%
OCCUPATIONAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%
ORGAN TRANSPLANTS	The Plan does not cover expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Medical Plan will be secondary. If an organ is sold, not donated, no benefits are paid for the donor's expenses.	100%	80%
PHYSICAL REHABILITATION FACILITY		100%	80%
PHYSICAL THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PHYSICIAN			
-Inpatient		100%	First \$8.00 per day, up to a \$960 maximum, paid at 100%; then 80%
-Office		\$10 Copay	80%
-Home		\$10 Copay	80%
<u>Consultation (Specialist)</u>			
-Inpatient		100%	80%
-Outpatient		\$10 Copay	80%
-Office		\$10 Copay	80%
<u>Second Medical Opinion</u>		\$10 Copay	80%
PREADMISSION TESTING		\$10 Copay	First \$150 paid at 100% per calendar year; then 80%
PREVENTATIVE/WELL CARE			
-Bone Density Testing		\$10 Copay	First \$150 paid at 100% per calendar year; then 80%
-Colonoscopy/Sigmoidoscopy		100%	80%
-GYN Office Visit	Maximum of 2 visits per calendar year.	\$10 Copay	80%
-Mammogram	Maximum of 1 per calendar year, unless Medical Necessity.	\$10 Copay	80%
-PAP Smear	Maximum of 2 per calendar year.	\$10 Copay When performed during GYN Office Visit an additional Copay will not be taken.	80%
-Prostate Cancer Screening (PSA)	Maximum of 2 per calendar year.	\$10 Copay	80%
-Routine Adult Physical	Maximum of 1 per calendar year. (includes appropriate labs and x-rays) The Plan does not cover immunizations, HPV vaccine, and Flu vaccinations.	\$10 Copay	80%
-Well Child Care	Up to and including age 12. (includes appropriate labs, x-rays and immunizations)	\$10 Copay	80%
-Hearing Exams		\$10 Copay	80%
-Hearing Aids		\$10 Copay	80%
-Eye Exams		Not Covered	Not Covered
-Frames and Lenses		Not Covered	Not Covered

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PRIVATE DUTY NURSING		Not Covered	Not Covered
RADIATION THERAPY			
-Outpatient Hospital		100%	First \$320 paid at 100% per calendar year; then 80%
-Any other place of service		100%	First \$320 paid at 100% per calendar year; then 80%
RESPIRATORY THERAPY			
-Outpatient Hospital		100%	80%
-Any other place of service		100%	80%
SLEEP DISORDERS	The Plan only covers sleep studies and apnea monitors.	\$10 Copay	80%
SMOKING CESSATION PRODUCTS		Not Covered	Not Covered
SPEECH THERAPY			
-Outpatient Hospital		100%	First \$50 paid at 100% per incident; then 80%
-Any other place of service		100%	First \$50 paid at 100% per incident; then 80%
SUBSTANCE ABUSE TREATMENT	Coinsurance does not accrue toward the Out-of-Pocket Maximum.		
-Detoxification		Included in Inpatient Rehabilitation	Included in Inpatient Rehabilitation
-Inpatient Rehabilitation	(Hospital or Behavioral Health Care Facility) Partial Hospitalization is covered in the same manner as any other Substance Abuse admission.	100%	100% Maximum of 30 days per calendar year.
-Inpatient Physician		100%	80%
-Outpatient/Office	Maximum of 24 visits per calendar year. Maximums are combined for In and Out-of-Network Providers. Maximums combined with Outpatient/Office Mental Illness Services.	\$10 Copay	80%

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery)			
<u>Surgeon</u> -Inpatient		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
-Outpatient		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
-Office		100%	Payable in accordance with Out-of-Network Surgical Allowance Schedule below
<u>Assistant Surgeon</u>	Maximum of 20% of the Surgeon's fee.	100%	80%
<u>Second Surgical Opinion</u> -Voluntary -Mandatory		\$10 Copay Not Required	80% Not Required

Out-of-Network Surgical Allowance Schedule

Appendectomy	\$280
Breast, removal of benign tumor	\$105
Fracture of femur, neck, intertrochanteric, simple or compound, open reduction	\$560
Fracture of radius and ulna, simple closed reduction	\$175
Gall bladder, removal of	\$420
Heart, removal of intra cardiac tumor	\$210
Hemorrhoidectomy, internal and external	\$245
Herniotomy, inguinal (single)	\$700
Hip, fusion of	\$420
Hysterectomy, total corpus and cervix	\$560
Mastoidectomy, modified radical or radical without skin graft	\$560
Prostatectomy, suprapubic, one or two stages	\$630
Spine and Spinal Cord, laminotomy for removal of intervertebral discs, lumbar	\$630
Stomach, partial removal of	\$105
Tonsils and Adenoids, removal of	\$140
Under age 18	
18 years or over	

- Above surgeries payable at 100% of allowance, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.
- For surgeries not listed in this schedule, maximum allowance is \$1,400 payable at 100%, after deductible, then 80% until the annual Out-of-Pocket Maximum is met.

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGERY CENTER (Freestanding Surgical Facility)		100%	80%
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)	The Plan only covers diagnostic x-rays and testing. Any treatment, including surgery, is not covered.	\$10 Copay	First \$150 paid at 100% per calendar year; then 80%
URGENT CARE FACILITY		100%	80%

PREScription DRUG EXPENSE BENEFIT

TYPE OF PROGRAM	IMPORTANT PROVISIONS	IN-NETWORK PHARMACY BENEFIT
RETAIL DRUGS	Copay is for each separate prescription or refill.	\$5.00 Copay – Generic Drug \$10.00 Copay – Brand Name Drug
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply. Copay is for each separate prescription or refill.	\$5.00 Copay – Generic Drug \$10.00 Copay – Brand Name Drug
DIABETIC SUPPLIES AND EQUIPMENT	Diabetic supplies and equipment that are covered as a Medical Expense Benefit will not be covered as a Prescription Drug Expense Benefit.	See benefit for Retail and Mail Order Maintenance Drugs.
<p>Copays under the Prescription Drug Expense Benefit do not count toward the Medical Out-of-Pocket Maximum. The Medical Expense Benefit portion of the Plan covers prescription drugs purchased from an Out-of-Network Pharmacy payable at 80%; subject to the Medical Deductible. Copays are not covered.</p>		
<p>Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.</p>		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.