

SCHEDULE OF MEDICAL BENEFITS
PLAN OPTION 3

**DEDUCTIBLE
PER CALENDAR YEAR**

<u>In-Network</u>	<u>Out-Of-Network</u>
\$2,500	\$5,000
per Covered Person	per Covered Person
\$7,500	\$15,000
per Family	per Family

**MAXIMUM OUT-OF-POCKET
PER CALENDAR YEAR
(includes deductibles)**

<u>In-Network</u>	<u>Out-Of-Network</u>
\$5,000	\$10,000
per Covered Person	per Covered Person
\$15,000	\$30,000
per Family	per Family

MAXIMUM LIFETIME BENEFIT
Unlimited

CALENDAR YEAR MAXIMUM BENEFIT
\$2,000,000

Details regarding Medical Benefits are in the Medical Benefits section.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS COPAYS	NON-PARTICIPATING PROVIDERS COPAYS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Physician Office Visits (including office visits that are billed separately for Preventive Services)	\$60	N/A	If a Physician is not seen the copay will be waived.
Surgery Performed in a Physician's Office	\$60	N/A	
Urgent Care Facility	\$60	\$60	
Emergency Services	\$300	\$300	The Emergency Services copay is waived if the Covered Person is admitted to the Hospital for a Medical Emergency. Great West must be notified at 800-925-2272 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.
Spinal Manipulations/Chiropractic Care	\$60	N/A	
Outpatient Physical, Occupational, and Speech Therapy	\$60	N/A	
Allergy Services	\$60	N/A	

Participating Provider vs. Non-Participating Provider Benefit Level

Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered services rendered by a Non-Participating Provider will be paid at the Non-Participating Provider benefit level. The Participating Provider benefit level will be paid for Non-Participating Provider services when a:

- Covered Person has an Emergency Medical Condition requiring immediate care
- Participating Provider is not available within a 50 mile radius of the Covered Person's residence
- Covered Person receives services by a Non-Participating Provider (e.g., anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Participating facility
- Participating Provider submits a specimen to a Non-Participating laboratory
- If an In-Network Physician or In-Network facility refers x-ray and laboratory services to an Out-of-Network Provider, those services will be paid at the In-Network level of benefits.
- Professional services that are provided by a non-Network Provider but rendered at a Network facility will be paid at the In-Network Provider level of benefits.

However, all other limitations, requirements and provisions of the Plan will apply including the Usual and Customary provision of the Plan. This exception does not apply in the event of consultations and other situations in which the Covered Person and/or the provider selected had the opportunity to select a Participating Provider, and exercised the right to receive services from a Non-Participating Provider.

Referrals by a Participating Provider to a Non-Participating Provider will be considered at the Non-Participating Provider benefit level.

Maximums

The maximums listed below in any one box are the total for Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed in two boxes under a benefit, the calendar year maximum is 60 days total which may be split between Participating and Non-Participating Providers.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive Services and Routine Care			
Preventive Services (includes office visit and any other eligible item or service billed and received at the same time as any preventive service benefit)	100% no deductible	60% U&C after deductible	Includes all items and services covered under the Preventive Services section under Covered Medical Expenses.
Office Visits (if billed separately)	100% after copay	60% U&C after deductible	
Any Other Eligible Item or Service (if received at the same time as any preventive service benefit but billed separately)	100% after copay	60% U&C after deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Routine Well Care (age 5 and over)	100% after copay	60% U&C after deductible	Includes but it not limited to: office visits; pap smear; prostate screening; gynecological exam; routine physical examination; x-rays; laboratory blood tests; immunizations/flu shots; Gardasil; well child age 5 and over; chlamydia screening; and ovarian surveillance. Note: Items and services covered under this section are in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.
Routine Well Child Care (up to age 5)	100% after copay	60% U&C no deductible	Includes but is not limited to: office visits, routine physical examination, laboratory blood tests, x-rays, immunizations, and developmental assessments until age 5. Note: Items and services covered under this section are in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.
Routine and Non-Routine (diagnostic) Mammograms and Colonoscopies	100% no deductible	100% U&C no deductible	Colonoscopy age 50 and over, or less than 50 if at high risk for colorectal cancer. Note: Items and services covered under this section are in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.
X-ray & Laboratory Services			
Pre-Admission and Pre-Surgical Testing, within 7 days of a scheduled Inpatient Hospital admission.	70% after deductible	60% U&C after deductible	
Diagnostic Charges (X-ray and Laboratory)	70% after deductible	60% U&C after deductible	Complex Imaging: The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Hospital Services, Specialized Treatment Facilities and Services			
Inpatient Hospital Services, including Room and Board	70% after deductible room and board limited to the semi-private room rate	60% U&C after deductible room and board limited to the semi-private room rate	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Intensive Care Unit	70% after deductible room and board limited to the ICU/CCU room rate	60% U&C after deductible room and board limited to the ICU/CCU room rate	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Outpatient Hospital	70% after deductible	60% U&C after deductible	
Birthing Center	70% after deductible	60% U&C after deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Home Health Care	70% after deductible 120 visits calendar year maximum	60% U&C after deductible 120 visits calendar year maximum	Any outpatient therapies provided under a home health care plan do not reduce the benefits listed below for outpatient therapies.
Hospice Care	70% no deductible	100% U&C no deductible	The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility	70% after deductible room and board limited to the facility's semi-private room rate 60 days calendar year maximum	60% U&C after deductible room and board limited to the facility's semi-private room rate 60 days calendar year maximum	The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Ambulance Service	70% after deductible	Paid at In-Network level of benefits	
Emergency Services due to an Emergency Medical Condition (includes all related charges) Follow-up treatment will not be considered under the Emergency Services benefit.	100% after copay	100% after copay	Great West must be notified at 800-925-2272 within 48 hours of the admission, even if the Covered Person is discharged within 48 hours of the admission. Use of an Emergency Room for a condition not considered an Emergency Medical Condition will not be covered by the Plan.
Urgent Care Facility	100% after copay	100% after copay	
Medical and Surgical Physician Services			
Allergy Services	100% after copay	60% U&C after deductible	
Spinal Manipulation/ Chiropractic Care	100% after copay 20 visits calendar year maximum	60% U&C after deductible 20 visits calendar year maximum	Maximum includes related x-ray and laboratory services.
Inpatient Surgery (includes anesthesiologists)	70% after deductible	60% U&C after deductible	The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Outpatient Surgery (facility charges, professional fees and ancillary charges)	70% after deductible	60% U&C after deductible	The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Surgery Performed in a Physician's Office	100% after copay	60% U&C after deductible	
Inpatient Physician Visits	70% after deductible	60% U&C after deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Occupational and Physical Therapy	100% after copay 20 visits combined calendar year maximum	60% U&C after deductible 20 visits combined calendar year maximum	
Outpatient Speech Therapy	100% after copay 20 visits calendar year maximum	60% U&C after deductible 20 visits calendar year maximum	
Outpatient Respiratory Therapy	70% after deductible 30 visits calendar year maximum	60% U&C after deductible 30 visits calendar year maximum	
Physician's Office Visits	100% after copay	60% U&C after deductible	Includes diagnostic services performed in the Physician's office. If a Physician is not seen the copay will be waived.
Maternity (prenatal and postnatal care) Initial Visit Subsequent Visits	100% after office visit copay 100% no deductible	60% U&C after deductible 60% U&C after deductible	
Telemedicine	70% after deductible	60% U&C after deductible	
Sleep Disorders (sleep apnea, nocturnal seizures and narcolepsy)	Same as any other illness	Same as any other illness	One annual sleep study. Lifetime Maximum of 5 studies. If Medically Necessary and approved, the Plan will cover more than 5 studies. The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Temporomandibular Joint Syndrome (TMJ)	70% after deductible	60% U&C after deductible	
Chemotherapy and Radiation Therapy	70% after deductible	60% U&C after deductible	The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Urgent Care Facility	100% after copay	100% after copay	
All Other Covered Medical and Surgical Expenses	70% after deductible	60% U&C after deductible	
Durable Medical Equipment, Supplies, Prosthetics and Orthotics			
Durable Medical Equipment	70% after deductible	Paid at In-Network level of benefits	
Medical Supplies	70% after deductible	60% U&C after deductible	
Prosthetics and Orthotics	70% after deductible	60% U&C after deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Prescription Drugs Not Eligible Under Prescription Drug Program	70% after deductible	60% U&C after deductible	This benefit applies to prescription drugs, medicines or supplies dispensed through a Physician's office and take-home prescription drugs from a Hospital. This does not cover prescription drugs, medicines or supplies that are eligible under the Prescription Drug Program.
Mental Disorders and Substance Use Disorders			
Mental Disorders and Substance Use Disorders <u>Inpatient</u>	100% after deductible	60% U&C after deductible	Inpatient: The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum. Emergency Services are paid at In-Network level unless otherwise required by law.
<u>Outpatient</u>	100% no deductible	60% U&C after deductible	
<u>Emergency Care</u> Ambulance	100% no deductible	100% U&C no deductible	
Emergency Services	100% no copay or deductible	100% no copay or deductible	
Prescription Drugs Not Eligible Under Prescription Drug Program	70% after deductible	70% U&C after In-Network deductible, subject to In-Network Out-of-Pocket Maximum	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS
PLAN OPTION 3

BENEFIT DESCRIPTION	
Calendar Year Deductible per Individual	\$300
Pharmacy Option (30-day supply – may receive a 90 day supply subject to 2 retail copays)	Copays After Deductible
Tier 1 - Generic Drugs	
Tier A	\$4; deductible waived
Tier B	\$15; deductible waived
Tier 2 - Formulary Brand Name Drugs	\$30 after deductible
Tier 3 - Non-Formulary Brand Name Drugs	Not Covered
Tier 4 - Specialty Injectables	\$150 after deductible
Mail Order Prescription Drug Option (90-day supply)	Copays after Deductible
Tier 1 - Generic Drugs	\$30; deductible waived
Tier 2 - Formulary Brand Name Drugs	\$60 after deductible
Tier 3 - Non-Formulary Brand Name Drugs	Not Covered
<p>NOTE: Any diabetic supplies that are not available through the Covered Person's pharmacy because the pharmacy does not have them available will still have the copay applied when ordered through the manufacturer.</p> <p>"Dispensed As Written" Drug Provision</p> <p>The Plan requires that retail pharmacies dispense Generic drugs when available unless the Physician specifically prescribes a Brand Name drug and marks the script "dispense as written." Should a Covered Person choose a Brand Name drug rather than the Generic equivalent when the Physician allowed a Generic drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Brand Name drug, in addition to the Brand Name drug copay and the Covered Person's share of the prescription's drug cost does not apply toward the out-of-pocket maximum.</p> <p>CuraScript Specialty Pharmacy Program</p> <p>Specialty drugs <u>MUST</u> be obtained directly from CuraScript Specialty Pharmacy Program, powered by Express Scripts, after 1 fill at a retail pharmacy. For more information about this program you may call Express Scripts at 888-773-7376.</p>	

Details regarding Prescription Drug Benefits are in the Prescription Drug Benefits section.