

IDENTIFYING NAME OR NUMBER OF PLAN: _____

“REIMBURSEMENT” TYPE PLANS

BENEFIT	PREFERRED PROVIDER PLAN		EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN
<p><u>MEDICAL BENEFITS</u></p>	<p><u>Participating Provider</u> (No Annual Deductible)</p>	<p><u>Non-Participating Provider</u> (All benefits payable after annual deductible unless otherwise stated)</p>	
Home, Office, or Office Consultation Visit	90% of Eligible Charges	70% of Eligible Charges	
Hospital Emergency Room Visits	90% of Eligible Charges	90% of Eligible Charges with no annual deductible	
Hospital or Skilled Nursing Facility Intensive Medical Care Medical/Surgical Consultation	90% of Eligible Charges	70% of Eligible Charges	
<p>Well-Child Care Visits</p> <ul style="list-style-type: none"> • 6 visits from birth through age 12 months (one additional visit is covered when newborn is discharged w/in 48 hours of birth); • 2 visits during age 1; • 1 visit each year during ages 2, 3, 4 and 5 	90% of Eligible Charges	70% of Eligible Charges with no annual deductible	
Immunization	<p>100% of Eligible Charges</p> <p>100% of Eligible Charges for immunizations in connection with well-child care services; no deductible</p>	70% of Eligible Charges	

Note: Eligible Charges are based on the lower of the actual charge on the claim, the discounted charge negotiated by the Association, or the charge listed for the service in the Association’s Schedule of Maximum Allowable Charges. For a covered service, which does not have a charge, listed in the Schedule, the Association will establish the Maximum Allowable Charge. The Association also reserves the right to annually adjust the charges listed in the Schedule of Maximum Allowable Charges.

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<p><u>SURGICAL BENEFITS</u></p> <p>Surgery in or out of the Hospital</p> <p> Non-Cutting Surgery</p> <p> Cutting Surgery</p> <p>Anesthesiology</p>	<p><u>Participating Provider</u> (No Annual Deductible)</p> <p>80% of Eligible Charges</p> <p>90% of Eligible Charges</p> <p>90% of Eligible Charges</p>	<p><u>Non-Participating Provider</u> (All benefits payable after annual deductible unless otherwise stated)</p> <p>70% of Eligible Charges</p> <p>70% of Eligible Charges</p> <p>70% of Eligible Charges</p>	
<p><u>DIAGNOSTIC LAB, X-RAY FILMS & RADIOLOGY BENEFITS</u></p> <p>X-Rays</p> <p>Lab Services and Diagnostic Tests</p> <p>Radiotherapy</p> <p>Screening by Low-Dose Mammography</p> <ul style="list-style-type: none"> • Ages 35-39: 1 baseline mammogram; • Ages 40 or older: 1 per calendar year; • A woman of any age may receive the screening more often if she, her mother, or sister has a history of breast cancer. 	<p>Out of the Hospital:</p> <p>80% of Eligible Charges</p> <p>80% of Eligible Charges</p> <p>80% of Eligible Charges</p> <p>80% of Eligible Charges</p>	<p>70% of Eligible Charges</p> <p>70% of Eligible Charges</p> <p>70% of Eligible Charges</p> <p>70% of Eligible Charges with no annual deductible</p>	
<p><u>HOSPITAL and FACILITY BENEFITS</u></p> <p>Inpatient Care (365 days per calendar year)</p> <p> Room and Board</p> <p> Intermediate & Isolation Care Units</p> <p> ICU and CCU</p>	<p>90% of Eligible Charges (Based on semiprivate room rate)</p> <p>90% of Eligible Charges</p> <p>90% of Eligible Charges</p>	<p>70% of Eligible Charges (Based on semiprivate room rate)</p> <p>70% of Eligible Charges</p> <p>70% of Eligible Charges</p>	

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<p><u>HOSPITAL and FACILITY BENEFITS</u> (continued)</p> <p>Hospital Ancillary Services (operating room, surgical supplies, drugs, dressings, antibiotics, oxygen, hospital anesthesia services and supplies, etc.)</p> <p>Outpatient Emergency Room (used in connection with medical and surgical services of emergent or urgent nature)</p> <p>Ambulatory Surgical Center</p>	<p><u>Participating Provider</u> (No Annual Deductible)</p> <p>90% of Eligible Charges</p> <p>90% of Eligible Charges</p> <p>90% of Eligible Charges</p>	<p><u>Non-Participating Provider</u> (All benefits payable after annual deductible unless otherwise stated)</p> <p>70% of Eligible Charges</p> <p>90% of Eligible Charges with no annual deductible</p> <p>70% of Eligible Charges</p>	
<p><u>MATERNITY BENEFITS</u></p> <p>Pregnancy, Childbirth or Termination of Pregnancy, and Related Medical Conditions</p> <p>Nurse-Midwife</p> <p>Birthing Centers</p>	<p>Regular plan benefits apply for physician, hospital, laboratory, and x-ray services, etc.</p> <p>100% of Eligible Charges</p> <p>Regular Hospital and Facility benefits apply</p>	<p>70% of Eligible Charges</p>	
<p><u>CONTRACEPTIVE PRESCRIPTION / DEVICES</u></p>	<p>\$10, 50% to 80%. Co-payments do not count toward the annual co- payment maximum</p>	<p>\$10, 50% to 80%, which does not count toward the annual deductible or annual co-payment maximum</p>	

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<p><u>MENTAL HEALTH BENEFITS</u></p> <p>In-Hospital Care from Psychiatrist, Psychologist, Clinical Social Worker, or Advanced Practice Registered Nurse (Up to 30 visits per calendar year.)</p> <p>Inpatient care (30 days per calendar year which count toward 365-day maximum for Hospital Benefits)</p> <p>Out-of-Hospital Care from Psychiatrist, Psychologist, Clinical Social Worker, or Advanced Practice Registered Nurse</p> <p>Psychological Testing</p> <p> Outpatient</p> <p> Inpatient</p>	<p><u>Participating Provider</u> (No Annual Deductible)</p> <p>90% of Eligible Charges</p> <p>Regular Hospital Benefits apply (Treatment of Serious Mental Illness is not subject to the inpatient service limitation)</p> <p>90% of Eligible Charges</p> <p>Up to 24 visits per calendar year (Treatment of Serious Mental Illness is not subject to the outpatient service limitation)</p> <p>80% of Eligible Charges</p> <p>90% of Eligible Charges</p>	<p><u>Non-Participating Provider</u> (All benefits payable after annual deductible unless otherwise stated)</p> <p>70% of Eligible Charges</p> <p>70% of Eligible Charges</p> <p>70% of Eligible Charges</p> <p>70% of Eligible Charges</p> <p>Each outpatient or inpatient psychological testing session shall count against the per calendar year maximum of 24 outpatient visits and 30 inpatient days of facility services.</p>	

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<p><u>SUBSTANCE ABUSE BENEFITS</u></p> <p>In-Hospital Care (includes qualified facility operated primarily for detoxification of alcoholics or drug addicts)</p> <p>Out-of-Hospital Care</p>	<p><u>Participating Provider</u> (No Annual Deductible)</p> <p>Regular Hospital and Facility benefits apply</p> <p>Substance abuse benefits have been incorporated into mental health benefits with the same level of benefits; benefits for substance abuse treatment services do not count against the in-hospital and out-of-hospital maximums under mental health benefits.</p>	<p><u>Non-Participating Provider</u> (All benefits payable after annual deductible unless otherwise stated)</p>	
<p><u>SKILLED NURSING FACILITY</u> (120 days per calendar year)</p>	<p>90% of Eligible Charges (Based on semiprivate room rate)</p>	<p>70% of Eligible Charges (Based on semiprivate room rate)</p>	
<p><u>HOME HEALTH CARE BENEFITS</u> (150 visits per calendar year by qualified home health care agency if physician certifies patient is homebound due to illness or injury)</p>	<p>100% of Eligible Charges</p>	<p>70% of Eligible Charges</p>	
<p><u>HOSPICE CARE</u></p>	<p>100% of Eligible Charges (For hospice services and hospice referral visits)</p>	<p>Not a benefit</p>	
<p><u>MEDICAL FOODS</u></p>	<p>80% of Eligible Charges Co-payments do not count toward the annual co-payment maximum</p>	<p>80% of Eligible Charges with no annual deductible. Co-payments do not count toward the annual co-payment maximum</p>	

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	<u>Participating Provider</u>	<u>Non-Participating Provider</u>	
<u>AMBULANCE BENEFITS</u> (Ground)	80% of Eligible Charges after annual deductible	70% of Eligible Charges after annual deductible	
<u>OTHER MEDICAL BENEFITS:</u> <ol style="list-style-type: none"> 1. Air Ambulance 2. Physical & Occupational Therapy - Inpatient benefit for participating provider is 90% of eligible charges 3. Speech Therapy 4. Allergy Testing & Treatment – one series of tests per calendar year 5. Blood & Blood Products 6. Appliances and Durable Medical Equipment 7. Chemotherapy for Malignancy 8. Recipient of Transplant Donor Services 9. Outpatient Injections 10. Evaluations for Use of Hearing Aids 11. Dialysis and Supplies 	80% of Eligible Charges after annual deductible	70% of Eligible Charges after annual deductible	
Maximum Benefits	\$1,000,000 lifetime maximum with \$10,000 renewal per calendar year per beneficiary		
Deductible	\$100 per beneficiary per calendar year or maximum \$300 per family per calendar year. The deductible applies to services where indicated.		
Maximum Annual Copayment	\$2,500 maximum annual co-payment (portion of Eligible Charges not paid by the plan) per beneficiary per calendar year or maximum \$7,500 per family per calendar year including the deductible. Thereafter, Association will pay 100% of Eligible Charges for covered services for the remainder of the calendar year		

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<p><u>EXCLUSIONS:</u></p> <p>No benefits will be paid in connection with services not described as covered in the certificate. Summary of exclusions is available upon request. (Please contact Department of Labor and Industrial Relations, Disability Compensation Division at (808) 586-9188.)</p>			