

SCHEDULE OF COVERAGE

PPO SELECT CHOICE – [PLAN I] [PLAN II] [PLAN III] [PLAN IV] [PLAN V] [PLAN VI] [PLAN VII]

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IDENTIFICATION NUMBER: [123-456-7890]
EFFECTIVE DATE: [April 1, 2005]

BENEFIT PROVISION	NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Calendar Year Deductibles <ul style="list-style-type: none"> ▪ Individual ▪ Family 	[\$250] [\$500] [\$1,000] [\$1,500] [\$2,500] [\$3,500] [\$5,000] [\$10,000] [\$750] [\$1,500] [\$3,000] [\$4,500] [\$7,500] [\$10,500] [\$15,000] [\$30,000]	[\$500] [\$1,000] [\$2,000] [\$3,000] [\$5,000] [\$7,000] [\$10,000] [\$20,000] [\$1,500] [\$3,000] [\$6,000] [\$9,000] [\$15,000] [\$21,000] [\$30,000] [\$60,000]
Coinsurance Amounts <ul style="list-style-type: none"> ▪ Individual ▪ Family 	\$3,000 \$6,000	\$6,000 \$12,000
Office Visit Copayment Amount Physician consultation only	\$25	None
Lifetime Maximum	\$5,000,000	
Inpatient Hospital Expense All usual Hospital services and supplies, including semiprivate room, intensive care and coronary care units	80% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Medical-Surgical Expense	80% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Extended Care Expense <ul style="list-style-type: none"> ▪ Skilled Nursing Facility ▪ Home Health Care ▪ Hospice Care 	100% of Allowable Amount	70% of Allowable Amount
	\$5,000 each Calendar Year \$5,000 each Calendar Year \$10,000 Lifetime Maximum	
Physical Medicine Services	80% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
	\$1,000 each Calendar Year	
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible up to \$1,500 Calendar Year benefit maximum	
Preventive Care (routine physical examinations, Well Child Care, hemmocult test, immunizations for Participants 8 years of age and over) vision and hearing exams. (Routine mammograms, colorectal cancer screening, prostate cancer screenings, and HPV/cervical cancer screenings are not subject to the \$300 maximum).	100% of Allowable Amount after Physician office visit Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
	\$300 Calendar Year Maximum	

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PPO SELECT CHOICE – [PLAN I] [PLAN II] [PLAN III] [PLAN IV] [PLAN V] [PLAN VI] [PLAN VII]

BENEFIT PROVISION	NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Routine Mammography Screening (For female Participants 35 years of age or older, limited to one each Calendar Year)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Non-Routine Diagnostic Mammography	80% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Breast Reconstruction	80% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Tests for Detection of Prostate Cancer	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Childhood Immunizations	100% of Allowable Amount No Deductible	
Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Tests for Detection of Colorectal Cancer	80% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Hearing Screening (when offered by Hospital during a birth admission)	80% of Allowable Amount No Deductible	70% of Allowable Amount No Deductible
Organ and Tissue Transplants (Liver, Heart, Heart/Lung [heart and one lung or heart and two lungs] Cornea, Lung.)	80% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
	\$300,000 Lifetime Maximum	

PRESCRIPTION DRUG PROGRAM

Plan Features

Applicable to all Plans

Deductible	\$200		
Calendar Year Maximum	\$3,000		
Copayment Amounts	Generic	Preferred Brand Name Drugs	Non-Preferred Brand Name Drugs
Retail Pharmacy			
▪ 30-Day Supply on each occasion dispensed	\$10	\$30	\$45
▪ 90-Day Supply	\$30	\$90	\$135
Mail Service			
▪ 90-Day Supply	\$20	\$60	\$90