

**BENEFITS HIGHLIGHT  
PREFERRED PROVIDER ORGANIZATION (HD15)**

PLEASE REFER TO THE RULES AND REGULATIONS AND SCHEDULE OF BENEFITS FOR PROVISIONS, LIMITATIONS AND MAXIMUMS.

Individual Deductible per calendar year	\$1500.00	
Family Deductible per calendar year	\$3000.00	
Maximum Out of Pocket	\$1500 / \$3000	\$5500 / \$11,000

Benefit Percentage: Reasonable and Customary covered charges are covered at the benefit percentage shown below.

	<b><u>Preferred Provider</u></b>	<b><u>Non-Preferred Provider</u></b>
<b><u>Inpatient</u></b>		
<b>Room and Board</b> (semi-private and misc. charges)		
Paid at	100%*	60%**
<b>Doctor Visits</b>		
Paid at	100%*	60%**
<b>Skilled Nursing Facility</b> (Semi-private Room) Limited to 90 days per calendar year		
Paid at	100%*	60%**
<b><u>Outpatient</u></b>		
<b>Doctor Visits</b> (home and office - not to include the delivery of an Antigen to the Participant)		
Paid at	100%*	60%**
<b>Emergency Room Charges</b> <sup>(1)</sup>		
Paid at	100%*	60%**
 (1) Emergency Care means care for a serious medical condition resulting from injury or illness which arises suddenly and requires immediate care and treatment to avoid jeopardy to the life or limb of a Participant. If services received do not meet Emergency Care definition, regular benefits apply. Treatment received from Non-Preferred Providers for emergency care, including ambulance, will be paid at 80%.		
Outpatient (continued)		
<b>X-ray Charges</b>		
Paid at	100%*	60%**
<b>Laboratory Charges</b>		
Paid at	100%*	60%**
<b>Surgery</b> Performed at Doctor's Office (including Doctor Charges)		
Paid at	100%*	60%**
<b>Doctor Charges</b> (other than in doctor's office)		
Paid at	100%*	60%**
<b>Facility Charges</b> (other than in doctor's office)		
Paid at	100%*	60%**
<b>Private Duty Nursing</b> - Limited to \$15,000 benefit maximum		
Paid at	100%*	60%**

	<u>Preferred Provider</u>	<u>Non-Preferred Provider</u>
<b>Home Health Care</b> - Limited to 100 visits per calendar year Paid at	100%*	60%**
<b>Outpatient Rehabilitation</b> Therapy - Limited to \$5,000.00 per calendar year Paid at	100%*	60%**
<b>Wellness Benefits<sup>(1)</sup></b> (Pap Smear/Pelvic, or Preventative Physical Exams) - Limited to \$300 @ 100% per calendar year Paid at	100%	100%
<b>Well-Child<sup>(2)</sup></b> Paid at	100% up to \$300 thereafter deductible is waived then 100%	100% up to \$300 thereafter deductible is waived then 60%
<b>Mental Health, Alcoholism, and Substance Abuse Inpatient<sup>(3)(5)</sup></b> - Limited to 30 days per calendar year Paid at	50%*	50%**
<b>Outpatient<sup>(4)</sup></b> - Limited to 20 visits per calendar year Paid at	100%*	50%**

Lifetime mental health, alcoholism and substance abuse maximum for inpatient and outpatient combined is 100 days/visits.

(1) Wellness benefits include physical exams. Physical exams are: (a) doctor's charges, (b) any tests performed, including x-ray and lab charges, and (c) charges for immunizations.

(2) "Well-Child Visit" means a visit to a provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), growth and development assessment. For older children, this also includes safety and health education counseling.

- Child wellness/0 through 12 years of age: in-network benefits - 100%, subject to member's copay with no maximum; out-of network benefits - 100% up to \$300, thereafter deductible is waived, paid at 60%.

Deductible is waived for these types of services:

Age 0-12 months 5 well-child visits

Age 13-35 months 2 well-child visits

Age 3-6 years 3 well-child visits

Age 7-12 years 3 well-child visits

Age 0-12 months Immunizations as recommended by the American Academy of Pediatrics

(3) Each two days of partial hospitalization care shall reduce by one day the 30 days available for inpatient care. Partial Hospitalization means continuous treatment for at least 3 hours but not more than 12 hours in any 24 hour period. Each day provided shall reduce by one day the available days provided under Alcoholism or Substance Abuse. Inpatient Alcoholism and Substance Abuse is limited to 30 days per calendar year.

(4) Outpatient Mental Health, Alcoholism and Substance Abuse is limited to 20 visits per calendar year.

(5) The coinsurance for Inpatient Mental Health, Alcoholism & Substance Abuse does not apply toward the maximum out of pocket.

	<u>Preferred Provider</u>	<u>Non-Preferred Provider</u>
<b>Hospice - Limited to 365 days<sup>(1)</sup></b> while covered. Paid at	100%*	60%**
<b>Routine Mammogram<sup>(2)</sup> -</b> Paid at	100%	100%
<b>Prostate Cancer Screening -</b> Paid at	100%	100%
<u>Replacement of Organs or Tissue<sup>(3)</sup></u> Performed at designated transplant facility, provided ONLY upon prior approval.	100%*	60%**
<u>Other Covered Charges</u> Paid at	100%*	60%**

**NOTE: Other provisions and limitations apply.**

- (1) Participant's doctor must certify that the Participant is terminally ill, and the Participant is expected to live less than six months.
- (2) See guidelines in subsection 3.10, 16.
- (3) See guidelines in subsection 3.11.

### **ALLOWABLE BENEFIT MAXIMUMS PER CALENDAR YEAR OR PER TREATMENT**

**Benefit maximums (Preferred and Non-Preferred combined):**

Maximum Covered Charge for Room and Board	Hospital Semi-Private Rate
Skilled Nursing Facility	Semi-private rate; limited to 90 days per calendar year
Outpatient Rehabilitation Therapy	Limited to \$5,000.00 benefit maximum per calendar year
Home Health Care	Limited to 100 visits per calendar year
Mental Health, Alcoholism, and Substance Abuse	
Inpatient	Limited to 30 days per calendar year.
Outpatient	20 Visits per calendar year
Routine Mammogram	One per mammography screening.
Prostate Cancer Screening	One screening.
Manual Manipulation of the spine	One visit per day, \$1,000 calendar year maximum, subject to R&C.

WHILE COVERED

**Benefit Maximum While Covered (Preferred and Non-Preferred combined):**

Mental Health, Alcoholism, and Substance Abuse	Limited to 100 days/visits benefit maximum while covered.
Hospice Care	Limited to 365 days while covered.
Private Duty Nursing	Limited to \$15,000 benefit maximum.
Maximum Benefit While Covered	Limited to \$3,000,000 benefit maximum.

**NOTE: Other provisions and limitations apply.**

\* Services are subject to the annual plan deductible.

\*\* Services are subject to the annual plan deductible and reasonable and customary charge limitations.