

## SCHEDULE OF BENEFITS

Except as noted, all benefits are subject to the annual plan deductible

<i>Benefit</i>	<i>Member Cost</i>
Allergy Testing	\$20
Allergy Treatment	None
Ambulance	\$100/trip
Annual Physical Exam at PCP (Primary Care Physician)	\$10 co-pay - Not subject to annual deductible
Annual Well Woman Visit at OB/GYN, includes: 1. Pap Smear 2. Pelvic Exam	\$10 co-pay - Not subject to annual deductible
Cardiac Rehabilitation at freestanding outpatient facility	\$20 per visit, maximum 60 visits per year
Cardiac Rehabilitation as hospital outpatient	\$50 per visit, maximum 60 visits per year
Chiropractor	\$20 per visit, maximum of 24 visits per year Not subject to annual deductible
Cleft Lip and Palate: includes: -speech therapy and nutrition services (covered child under 18)	SAAI
Complications of Pregnancy	SAAI
Contraceptive, Oral ( <b>optional benefit</b> ) (If selected)      Generic	\$10 co-pay - Not subject to annual deductible
Contraceptive, Oral ( <b>optional benefit</b> ) (If selected)      Brand	\$20 co-pay - Not subject to annual deductible
Deductible per year	\$500
Deductible maximum per family per year	2X Deductible
Dental	See Attached Dental Benefit Schedule Not subject to annual deductible
Dental procedures and anesthesia - (covered child under 8, in hospital only)	SAAI
Dermatologist	\$20 per visit. Maximum of 5 visits per year w/o a referral
<b>Diagnostic Services:</b>	Applicable co-pay per service
1. CT Scan	\$150
2. MRI	\$200
3. Mammogram at a free-standing Radiology center	None
4. Nuclear Medicine	\$200
5. PET Scan	\$300
6. Ultrasound	\$100
7. EKG, etc	None
8. Laboratory - Not subject to annual deductible	None
9. X-Ray, not otherwise specified	\$20
Durable Medical Equipment	\$20 co-pay - \$1000 max. per year* *max. per year does not apply to diabetic equipment Not subject to annual deductible
Emergency Room Participating Hospital	\$100 co-pay (waived if admitted to hospital)
Emergency Room Non-Participating Hospital	\$150 co-pay (waived if admitted to hospital)
Hearing, Routine Exam (under 18, included in annual physical)	\$20 (maximum 1 time per year) Not subject to annual deductible
Home Health Care	\$10 per day, 60 days maximum per year Not subject to annual deductible
Hospice Facility, In-Patient	\$100 per day for the first 2 days per admission
Hospice Out Patient	\$25 per visit
Hospital Deductible (per admission)	\$500
Hospital, Participating - Inpatient	No additional co-pay
Hospital Non Par In Service Area - Inpatient	No additional co-pay
Hospital Outpatient	\$100 per visit
Immunization (Hepatitis B not covered except for child under 18)	Included in PCP Office Visit

UNIVERSAL HEALTH CARE - UNIVERSAL PLUS 500

## SCHEDULE OF BENEFITS

UNIVERSAL HEALTH CARE - UNIVERSAL PLUS 500

<i>Benefit</i>	<i>Member Cost</i>
Lifetime Maximum Benefit	\$2,000,000
Mastectomy (surgery, treatment, and reconstruction)	SAAI
Maternity (if <b>optional rider</b> is selected)	\$200 Hospital; \$20 OB/GYN per visit; \$35 Delivery Maternity benefit is not subject to the annual deductible
Mental Health and Substance Abuse - Inpatient (Maximum of 10 days can be used for Substance Abuse)	\$200 per day for first 2 days, Max. 30 days per contract year Not subject to annual deductible
Mental Health and Substance Abuse - Outpatient (Maximum of 10 visits can be used for Substance Abuse)	\$20 per visit, Maximum 30 visits per year Not subject to annual deductible
Office Visit, Primary Care	\$10 co-pay - Not subject to annual deductible
OB/GYN	\$20 per visit - Not subject to annual deductible
Out of pocket maximum	\$2500 maximum per year
Out of pocket family maximum per year.	2 X maximum per year
Outpatient Surgery Center	\$50
Outpatient Surgery at Hospital	\$100
Physician Inpatient visits	None
Podiatrist (routine services not covered)	\$20, max. 2 visits per year without a referral
Prescriptions, ( <b>optional benefit</b> ) Generic-Formulary	\$10 - Not subject to annual deductible
Brand-Formulary	\$20 - Not subject to annual deductible
Prescriptions, ( <b>optional benefit</b> ) Generic-Formulary	\$20 - Not subject to annual deductible
Mail order Brand-Formulary	\$40 - Not subject to annual deductible
Prosthetics and Orthotics	\$50 per item - \$1000 max. per year Not subject to annual deductible
Rehabilitation - In Patient	\$50 per visit, maximum 15 visits per year
Rehabilitation - Out Patient	\$20 per visit, maximum 60 visits per year
Skilled Nursing Facility 1st thru 7th Day	None
(Limit of 21 days per year) 8th thru 21st Day	\$50 co-pay per day
Specialist	\$20 - Not subject to annual deductible
Therapy: Outpatient	
1. Chemo in the Doctor's office	\$20
2. Chemo as a hospital outpatient	\$100 per visit
3. Chemo in the Surgery Center	\$50 Per visit
4. Hearing Therapy	\$20 per visit, 60 visits per year
5. Occupational	\$20 per visit, 60 visits per year
6. Physical Therapy	\$20 per visit, 60 visits per year
7. Speech	\$20 per visit, 60 visits per year
8. Radiation	\$20 per visit
9. Injectable drug therapy (self-injected not covered except for diabetes)	20% (diabetes injectables Not subject to annual deductible)
TMJ: Covers: Hospital, surgery, manipulation under anesthesia, exam, and diagnostic x/rays	SAAI
Transplant (only with plan approval) (Covers: Bone Marrow, Cornea, Heart, Liver (limited), Kidney)	SAAI
Urgent Care Center - In Network	\$25 per visit
Urgent Care Center - Out of Network	\$50 per visit
Vision (Comprehensive Annual Exam)	\$0 co-pay
Vision (Frames, Lenses, Contact Lenses)	See Attached Vision Benefit Schedule
Vision	Not subject to annual deductible
Well Child Care	\$10 co-pay - not subject to annual deductible

\* Definitions; For the purpose of this Schedule, the following terms are used: SAAI=Same as any other illness, w/o = Without; Per Year = Per contract year, OV = Office Visit  
Out-of-pocket is in addition to the plan, and hospital deductible