IDENTIFYING NAME OR NUMBER OF PLAN: _____

**"REIMBURSEMENT" TYPE PLANS**

| BENEFIT | PREFERRED PROVIDER PLAN | | EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN |
|---|---|---|---|
| | **Participating Provider** (No Annual Deductible unless otherwise stated) | **Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated) | |
| **PREVENTIVE CARE BENEFITS** | | | |
| Screening Services<br>• Grade A & B recommendations of the U.S. Preventive Services Task Force | 100% of Eligible Charges | 70% of Eligible Charges | |
| Screening by Low-Dose Mammography<br>• Ages 35-39: 1 baseline mammogram;<br>• Ages 40 or older: 1 per calendar year;<br>• A woman of any age may receive the screening more often if she, her mother, or sister has a history of breast cancer. | 100% of Eligible Charges | 70% of Eligible Charges with no annual deductible | |
| Well-Child Care Visits<br>• 7 visits from birth through age 12 months;<br>• 3 visits during age 1;<br>• 2 visits during age 2;<br>• 1 visit each year through age 21 | 100% of Eligible Charges | 70% of Eligible Charges with no annual deductible | |
| Well-Child Immunization | 100% of Eligible Charges | 100% of Eligible Charges with no deductible | |
| Immunization | 100% of Eligible Charges | 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.

**"REIMBURSEMENT" TYPE PLANS**

| BENEFIT | PREFERRED PROVIDER PLAN | | EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN |
|---|---|---|---|
| | **Participating Provider** (No Annual Deductible unless otherwise stated) | **Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated) | |
| **MEDICAL BENEFITS** | | | |
| 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<br>Intensive Medical Care<br>Medical/Surgical Consultation | 90% of Eligible Charges | 70% of Eligible Charges | |
| **SURGICAL BENEFITS** | | | |
| Surgery in or out of the Hospital | | | |
| Non-Cutting Surgery | 80% of Eligible Charges | 70% of Eligible Charges | |
| Cutting Surgery | 90% of Eligible Charges | 70% of Eligible Charges | |
| Anesthesiology | 90% of Eligible Charges | 70% of Eligible Charges | |
| **DIAGNOSTIC LAB, X-RAY FILMS & RADIOLOGY BENEFITS** | Out of the Hospital: | | |
| X-Rays | 80% of Eligible Charges | 70% of Eligible Charges | |
| Lab Services and Diagnostic Tests | 80% of Eligible Charges | 70% of Eligible Charges | |
| Radiotherapy | 80% of Eligible Charges | 70% of Eligible Charges | |

**"REIMBURSEMENT" TYPE PLANS**

| BENEFIT | PREFERRED PROVIDER PLAN | | EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN |
|---|---|---|---|
| | **Participating Provider** (No Annual Deductible unless otherwise stated) | **Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated) | |
| **HOSPITAL and FACILITY BENEFITS** Inpatient Care (365 days per calendar year) | | | |
| Room and Board | 90% of Eligible Charges (Based on semiprivate room rate) | 70% of Eligible Charges (Based on semiprivate room rate) | |
| Intermediate & Isolation Care Units | 90% of Eligible Charges | 70% of Eligible Charges | |
| ICU and CCU | 90% of Eligible Charges | 70% of Eligible Charges | |
| Hospital Ancillary Services (operating room, surgical supplies, drugs, dressings, antibiotics, oxygen, hospital anesthesia services and supplies, etc.) | 90% of Eligible Charges | 70% of Eligible Charges | |
| Outpatient Facility | 90% of Eligible Charges | 70% of Eligible Charges | |
| Outpatient Emergency Room (used in connection with medical and surgical services of emergent or urgent nature) | 90% of Eligible Charges | 90% of Eligible Charges with no annual deductible | |
| Ambulatory Surgical Center | 90% of Eligible Charges | 70% of Eligible Charges | |
| **MATERNITY BENEFITS** | | | |
| Pregnancy, Childbirth or Termination of Pregnancy, and Related Medical Conditions | Regular plan benefits apply for physician, hospital, laboratory, and x-ray services, etc. | | |
| Birthing Centers | Regular Hospital and Facility benefits apply | | |

**"REIMBURSEMENT" TYPE PLANS**

| BENEFIT | PREFERRED PROVIDER PLAN | | EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN |
|---|---|---|---|
| | **Participating Provider** (No Annual Deductible unless otherwise stated) | **Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated) | |
| **CONTRACEPTIVE PRESCRIPTION / DEVICES** | Varied Copayments ($10-20%-50%). Copayments do not count toward the annual copayment maximum | Varied Copayments ($10-20%-50%), which do not count toward the annual deductible or annual copayment maximum | |
| **MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS** | | | |
| In-Hospital Care from a licensed physician, Psychiatrist, Psychologist, Clinical Social Worker, Marriage and family therapist, licensed mental health counselor, or Advanced Practice Registered Nurse | 90% of Eligible Charges | 70% of Eligible Charges | |
| Inpatient Care | Regular Hospital and Facility Benefits apply | | |
| Out-of-Hospital Care from a licensed physician, Psychiatrist, Psychologist, Clinical Social Worker, Marriage and family therapist, licensed mental health counselor, or Advanced Practice Registered Nurse | 90% of Eligible Charges | 70% of Eligible Charges | |
| Outpatient Care | Regular Hospital and Facility Benefits apply | | |
| Psychological Testing | | | |
| Outpatient | 80% of Eligible Charges | 70% of Eligible Charges | |
| Inpatient | 90% of Eligible Charges | 70% of Eligible Charges | |

**"REIMBURSEMENT" TYPE PLANS**

| BENEFIT | PREFERRED PROVIDER PLAN | | EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN |
|---|---|---|---|
| | **Participating Provider**<br>(No Annual Deductible unless otherwise stated) | **Non-Participating Provider**<br>(All benefits payable after annual deductible unless otherwise stated) | |
| **SKILLED NURSING FACILITY**<br>(120 days per calendar year) | 90% of Eligible Charges<br>(Based on semiprivate room rate) | 70% of Eligible Charges<br>(Based on semiprivate room rate) | |
| **HOME HEALTH CARE BENEFITS**<br>(150 visits per calendar year by qualified home health care agency if physician certifies patient is homebound due to illness or injury) | 100% of Eligible Charges | 70% of Eligible Charges | |
| **HOSPICE CARE** | 100% of Eligible Charges<br>(For hospice services and hospice referral visits) | Not a benefit | |
| **MEDICAL FOODS** | 80% of Eligible Charges<br>Copayments do not count toward the annual copayment maximum | 80% of Eligible Charges with no annual deductible. Copayments do not count toward the annual copayment maximum | |

**"REIMBURSEMENT" TYPE PLANS**

| BENEFIT | PREFERRED PROVIDER PLAN | | EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN |
|---|---|---|---|
| | **Participating Provider** (No Annual Deductible unless otherwise stated) | **Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated) | |
| **AMBULANCE BENEFITS** (Ground) | 80% of Eligible Charges after annual deductible | 70% of Eligible Charges after annual deductible | |
| **OTHER MEDICAL BENEFITS:** | 80% of Eligible Charges after annual deductible | 70% of Eligible Charges after annual deductible | |
| 1. Air Ambulance<br>2. Allergy Testing & Treatment<br>3. Appliances and Durable Medical Equipment<br>4. Blood & Blood Products<br>5. Chemotherapy – Infusion /Injections<br>6. Dialysis and Supplies<br>7. Evaluations for Use of Hearing Aids<br>8. Outpatient Injections<br>9. Outpatient Physical & Occupational Therapy – Inpatient benefit for participating provider is 90% of eligible charges; no deductible<br>10. Outpatient Speech Therapy – Inpatient benefit for participating provider is 90% of eligible charges; no deductible<br>11. Recipient of Transplant Donor Services | | | |
| **Maximum Benefits** | No lifetime dollar maximum | | |
| **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 copayment (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 | | |

**"REIMBURSEMENT" TYPE PLANS**

| BENEFIT | PREFERRED PROVIDER PLAN | | EXPLAIN ANY VARIATION FROM PREFERRED PROVIDER PLAN |
|---|---|---|---|
| | **Participating Provider** (No Annual Deductible unless otherwise stated) | **Non-Participating Provider** (All benefits payable after annual deductible unless otherwise stated) | |
| **EXCLUSIONS**:<br><br>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.) | | | |