MEDICAL BENEFITS SCHEDULE
HEALTH SAVINGS PLAN

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$2,800	$5,000
Per Family Unit	$5,000	$10,000
The Network Deductible amounts will be combined with the Non-Network Deductible amounts.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (includes deductible)		
Per Covered Person	$6,350	$12,700
Per Family Unit	$12,700	$25,400
The Network Out-of-Pocket amounts will be combined with the Non-Network Out-of-Pocket amounts.		
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum: Non-Precertification Penalties Amounts over Usual and Reasonable Charges		
COVERED CHARGES		
Inpatient Hospital Services		
Room, Board, and Miscellaneous	80% after deductible	70% after deductible
Outpatient Hospital Services		
Surgical Facilities	80% after deductible	70% after deductible
Other Outpatient Services	80% after deductible	70% after deductible
Emergency Room Visit (including related charges)	80% after deductible	Paid same as Network
Emergency Room: The utilization review administrator CareFactor should be notified at (614) 766-5800 within 48 hours (or 2 business days) of admission, even if the patient is discharged within 48 hours (or 2 business days) of the admission.		
Medical Emergency	80% after deductible	Paid same as Network
Skilled Nursing Facility	80% after deductible 90 day Calendar Year maximum	70% after deductible 90 day Calendar Year maximum
Urgent Care Services	80% after deductible	70% after deductible
Physician Services		
Inpatient visits	80% after deductible	70% after deductible
Office visits (including related services)	80% after deductible	70% after deductible
Surgery	80% after deductible	70% after deductible
Allergy serum and injections	80% after deductible	70% after deductible
Treatment of Accidental Injury to Sound Natural Teeth	80% after deductible Limited to $3,000 per accident	70% after deductible Limited to $3,000 per accident
Diagnostic Testing (X-ray & Lab)	80% after deductible	70% after deductible
Radiology/Pathology	80% after deductible	Paid same as Network
Imaging Services (MRI, CT/PET Scans, etc.)	80% after deductible	70% after deductible
Home Health Care	80% after deductible 100 visits per Calendar Year combined	70% after deductible 100 visits per Calendar Year combined

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	80% after deductible	70% after deductible
Private Duty Nursing	80% after deductible 82 visits per Calendar Year	70% after deductible 82 visits per Calendar Year
Anesthesia	80% after deductible	Paid same as Network
Ambulance Service	80% after deductible	Paid same as Network
Wig After Chemotherapy/Radiation	80% after deductible $400 Lifetime maximum	70% after deductible $400 Lifetime maximum
Occupational Therapy	80% after deductible 20 visit Calendar Year maximum	70% after deductible 20 visit Calendar Year maximum
Physical Therapy	80% after deductible 20 visit Calendar Year maximum	70% after deductible 20 visit Calendar Year maximum
Spinal Manipulation Chiropractic	80% after deductible 12 visit Calendar Year maximum	70% after deductible 12 visit Calendar Year maximum
Cardiac Rehabilitation	80% after deductible 36 visit Calendar Year maximum	70% after deductible 36 visit Calendar Year maximum
Speech Therapy	80% after deductible 20 visit Calendar Year maximum	70% after deductible 20 visit Calendar Year maximum
Pulmonary Rehabilitation	80% after deductible 20 visit Calendar Year maximum	70% after deductible 20 visit Calendar Year maximum
Durable Medical Equipment	80% after deductible	70% after deductible
Mental Disorders/Substance Abuse	Paid based on the type of service(s) received.	
Preventive Care		
Routine Well Adult Care	100%	70% after deductible
Including, but not limited to: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, immunizations/flu shots, colonoscopies, bone density scans, stress tests, sigmoidoscopies, and services as required by law.		
Routine Well Child Care	100%	70% after deductible
Including, but not limited to: office visits, routine physical examination, laboratory tests, x-rays, immunizations, and services as required by law.		
Organ Transplants	Paid based on the type of service(s) received.	
Other Medical Services and Supplies	80% after deductible	70% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE
HEALTH SAVINGS PLAN

PRESCRIPTION DRUG BENEFIT	
	COPAYMENT
Pharmacy Option (30 Day Supply)	
Generic Drugs	80% after deductible
Formulary Brand Name Drugs	80% after deductible
Non-Formulary Brand Name Drugs	80% after deductible
Specialty Drugs	80% after deductible
Mail Order Option (90 Day Supply)	
Generic Drugs	80% after deductible
Formulary Brand Name Drugs	80% after deductible
Non-Formulary Brand Name Drugs	80% after deductible
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.	

Note: Prescription Drug expenses under the Prescription Drug Program do apply to the Calendar Year Deductible. Prescription Drug expenses do apply to the Out-of-Pocket Maximum under Medical Benefits section of this Plan.