SCHEDULE OF BENEFITS – PLAN M3

Effective June 1, 2018

When you need to see a physician, a physician network, PHCS, is utilized for all physician services (primary care and specialists) and ancillary services. This gives you access to a wide network of providers.

When you need care from a hospital or outpatient facility, Value-Based Fair Price comes into play to keep your costs down. Your physician will recommend a hospital or outpatient facility, as usual. They will pre-certify your treatment based on the Plan Guidelines. Based on rates established by Medicare and other resources, a fair price will be identified for your treatment. The facility will then be advised up front of the allowable charge, which is almost always lower than what they would normally charge, and proceed with scheduled services. As usual, you will be responsible for any copays, deductible, and coinsurance up to the maximum amounts shown below. This Plan uses the PHCS Network for physicians and ancillary providers only. This means that your access includes the full network minus hospitals. You may search online at www.multiplan.com/healthscope for a PHCS preferred provider.

If you have questions about your benefits please contact HealthSCOPE Benefits Customer Care at (800) 397-9598.

Benefit Maximums	
Lifetime Maximum Benefits	Inpatient Mental/Nervous Treatment and Alcohol and Substance Abuse – 120 days Assisted Reproduction Techniques - $20,000
Calendar Year Maximum Benefits	Outpatient Mental/Nervous Treatment and Alcohol and Substance Abuse - 52 visits Skeletal Adjustment - $750
Deductible and Out-of-Pocket Maximum	
Calendar Year Deductible • Individual • Family	 $2,500 $5,000
Calendar Year Out-of-Pocket* • Individual • Family	 $3,500 $7,000

*** The following expenses do not apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum**:

- Spinal adjustment charges;
- Penalties for failure to pre-certify when required by the Plan;
- Any ineligible expenses;
- Any expenses in excess of the Lifetime or Calendar Year Maximums.

Description of Service	Benefit
All charges are subject to the Calendar Year Deductible unless otherwise noted.	
Inpatient Hospital Services for treatment of illness or injury (including Mental/Nervous, Alcohol and/or Substance Abuse)	85%
Outpatient Surgery at a Hospital or Ambulatory Surgical Facility (except Emergency Room treatment)	85%
Emergency Room Treatment (hospital and emergency room physician fee only). This does not include ambulance transportation.	$300 Copay then 85%, no deductible
Urgent Care Center/Facility Facility Charge Physician Charge	 $40 then 90%, no deductible 90%
Medically Necessary Ambulance Transportation	80%
Pre-admission Testing	100%, no deductible
Physician's Inpatient Visits (includes Medical, Surgical, Mental/Nervous, Alcohol and/or Substance Abuse visits)	85%
Second Surgical Opinion	100%, no deductible
Diagnostic Laboratory Services at other than an Independent Lab Diagnostic Laboratory Services at an Independent Lab	85% 100%, no deductible
Diagnostic X-ray Expenses	85%
Organ and Tissue Transplants	90%, no deductible
Surgical Treatment of Morbid Obesity	85%

Description of Service	Benefit
All charges are subject to the Calendar Year Deductible unless otherwise noted.	
Primary Doctor Office Visit or Retail Clinic Visit (Includes general or family practice, internists, pediatricians and OB/GYN physicians)	$25 Copay then 100%, no deductible
Specialist Physician Office Visit	$30 Copay then 100%, no deductible
All services other than the Office Visit during the Primary Doctor or Specialist Office Visit	85%
Skeletal Adjustment	50%
Durable Medical Equipment	85%
Physical, Speech or Occupational Therapy	85%
Home Health Care Home Infusion Skilled Nursing Facility Hospice Care	85%
Covered Prescription Drugs not covered under the Drug Card Benefit	80%
All Other Covered Expenses	85%

PRESCRIPTION DRUG CARD BENEFIT

You have the option to fill the first two months of a newly prescribed maintenance medication at any local retail pharmacy for the normal 30 day co-pay. After the first two fills of a maintenance medication each fill afterward will be required to be a 90 day fill at either a participating 90 day retail pharmacy or through Home Delivery. You can buy up to a 30 day supply of any covered medication that is not a maintenance medication and is not a specialty medication at any retail pharmacy.

You are required to purchase specialty drugs through Accredo, an Express Scripts specialty pharmacy and in most cases are limited to a 30 day supply. Specialty drugs are very high cost biologic and injectable drugs that are not typically stocked by retail pharmacies. **If a member tries to fill a specialty script at retail, the pharmacy will notify the member that the drug must be ordered from Accredo**. You may begin using Accredo for those specialty medications at any time by calling 1-877-ACCREDO (222-7336)**.**

Prescription Drug Copayments	Retail 30 day supply	Retail 90 day supply Maintenance drugs after first 2 fills	Home Delivery up to 90 day supply
Generic	$12	$36	$30
Preferred Brand	$25	$85	$55
Non-Preferred	$40	$130	$100
Oral and Injectable Specialty Drugs	Copay plus 3%	Copay plus 3%	Copay plus 3%
All specialty drugs (oral and injectable) will have a maximum copay of $150 per month.			

WELLNESS BENEFIT

The Plan covers certain routine health care services and recommended preventive services based on guidelines published by the USPSTF, CDC, and HRSA (the Guidelines), as described under Wellness / Preventive Services in the Covered Major Medical Expenses section of the Plan Document and Summary Plan Description and as outlined on the following page.

Description of Wellness Service	Benefit
Charges are not subject to the Calendar Year Deductible except as noted.	
Wellness Office Visits for Children (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%
Wellness Office Visits for Adolescents and Adults (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%
Childhood Immunizations and Vaccinations per Guidelines	100%
Adult Immunizations and Vaccinations per Guidelines; Includes HPV vaccine	100%
Flu vaccine	100%
Pneumonia vaccine per Guidelines	100%
Zoster (Zostavax) for Shingles per Guidelines	100%
Tetanus, Diphtheria Toxoids per Guidelines	100%
Hepatitis A and B per Guidelines	100%
Combined Tetanus, Diphtheria and Pertussis (TDAP) per Guidelines	100%
Mammogram (limited to 1 per calendar year)	100%
Routine Pap Smear (limited to 1 test per calendar year)	100%
Routine PSA Test (limited to 1 test per calendar year)	100%
Routine Laboratory, X-ray and Screening Tests recommended by Guidelines: No dollar limit.	100%
Routine Screening for Colorectal Cancer using fecal occult blood testing, Cologuard, sigmoidoscopy or colonoscopy (age 50 and over). Frequency as provided by Guidelines.	100%
Other recommended preventive services (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%

Recommended Preventive Services

The following is a **partial list** of services that are covered by the Plan when specifically listed under the Wellness Benefit or when recommended for individuals of the patient's age, gender or health risk factors, in accordance with Guidelines published by the USPSTF, CDC or HRSA. An up-to-date list of the current Guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/

For Children:

- Well child exams
- Standard routine immunizations recommended by the Guidelines
- Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia
- Gonorrhea preventive medication for eyes in at risk newborns
- Standard metabolic screening panel for inherited enzyme deficiency diseases
- Screening and counseling for obesity
- Evaluation for fluoride treatment and fluoride supplements
- Behavioral assessments
- Screening for autism (at 18 and 24 months)
- Vision screening
- Oral health assessment
- Developmental screening, autism screening and behavioral assessment
- Screening for lead and tuberculosis

For Women:

- Annual physical exam
- Annual screening mammogram
- Annual pap smears, screening for cervical cancer, HPV testing
- Evaluation, counseling and genetic testing for BRCA breast cancer gene and/or for chemoprevention for women at high risk for breast cancer due to family history or other factors
- Screening pregnant women for anemia, gestational diabetes, iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility
- Screening for gonorrhea, chlamydia, syphilis
- Counseling and equipment to promote and aid with breast feeding
- Folic acid supplements for pregnant women
- Screening for domestic and interpersonal violence
- Osteoporosis screening (age 60 or older)
- FDA approved contraceptive methods, sterilization procedures and counseling

A detailed listing of women's preventive services can be found at: http://www.hrsa.gov/womensguidelines/

For Men:

- Annual physical exam
- Annual PSA test/screening for prostate cancer
- Screening for abdominal aortic aneurysm (ages 65 – 75 with history of smoking)

For Adolescents and Adults at Appropriate Ages or With Risk Factors:

- Screening for elevated cholesterol and lipids, high blood pressure, diabetes
- Screening and counseling for certain sexually transmitted diseases and HIV
- Screening and counseling for hepatitis B and C
- Screening and counseling for alcohol abuse in a primary care setting
- Screening, counseling and interventions for tobacco use
- Screening and counseling for obesity, diet and nutrition
- Screening for depression in a primary care setting
- Screening for colorectal cancer (ages 50 – 75)
- Screening for lung cancer (ages 55 – 80 with history of smoking)
- Standard routine immunizations recommended by the Guidelines
- Aspirin to prevent cardiovascular disease (women ages 55 – 79; men ages 45 – 79)

The Plan may impose reasonable frequency limits or may use reasonable medical management techniques to ensure that care is provided in an appropriate setting.