SCHEDULE OF COVERAGE
PPO SELECT SAVER - PLAN V

SUBSCRIBER: **SULLIVAN, MARY L**

IDENTIFICATION NUMBER: **000175 903646929**

EFFECTIVE DATE: **December 1, 2013**

BENEFIT PROVISIONS	NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Calendar Year Deductibles		
▪ Individual	$3,500	$7,000
▪ Family	$10,500	$21,000
Coinsurance Amounts		
▪ Individual	$3,000	$6,000
▪ Family	$9,000	$18,000
Inpatient Hospital Expense	75% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Medical-Surgical Expense	75% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Extended Care Expense ▪ Skilled Nursing Facility ▪ Home Health Care ▪ Hospice Care	100% of Allowable Amount	70% of Allowable Amount
Physical Medicine Services	75% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	75% of Allowable Amount after Calendar Year Deductible	
Preventive Care	100% of Allowable Amount No Deductible	60% of Allowable Amount after Calendar Year Deductible
Childhood Immunizations	100% of Allowable Amount No Deductible	
Hearing Screening	100% of Allowable Amount No Deductible	60% of Allowable Amount No Deductible
Organ and Tissue Transplants	75% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

PHARMACY BENEFITS			
Plan Features ***Applicable to all Plans***			
Deductible	**$200**		
Copayment Amounts	**Generic Drug**	**Preferred Brand Name Drug**	**Non-Preferred Brand Name Drug**
Retail Pharmacy ▪ 30-Day Supply on each occasion dispensed ▪ 90-Day Supply	 $10 $30	 $40 $120	 $55 $165
Mail Service ▪ 90-Day Supply	 $20	 $80	 $110

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.