

Enhanced MEHIP (Municipal Employees Health Insurance Plan)

SCHEDULE OF BENEFITS – Preferred Provider Organization (PPO)

This schedule generally describes the benefits available for Covered Services. For a more detailed explanation of benefits provided, you should refer to the appropriate section of the Summary Booklet. This Schedule of Benefits is subject to all the terms, conditions, and limitations set forth in the Summary Booklet.

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Covered Person Annual Deductible	Not Applicable	\$1000 individual \$2000 two person \$2000 family
Covered Person Coinsurance	Not Applicable	20 %
Covered Person Cost-Share Maximum	Not Applicable	\$2000 individual \$4000 two person \$4000 family
Lifetime Maximum	Unlimited	\$1,000,000
PREVENTIVE SERVICES		
Well Child Care: 6 exams from birth to 1 year of age 6 exams 1 through 5 years of age 1 exam every 2 Calendar Years 6 through 10 years of age 1 exam every Calendar Year 11 through 21 years of age	\$0 Co-pay	Deductible & Coinsurance
Adult Physical Examinations: 1 exam every 5 Calendar Years 22 through 29 years of age 1 exam every 3 Calendar Years 30 through 39 years of age 1 exam every 2 Calendar Years 40 through 49 years of age 1 exam per Calendar Year 50 years of age and older	\$0 Co-pay	Deductible & Coinsurance
Routine Gynecological Visit 1 visit per Calendar Year including pap smear	\$0 Co-pay	Deductible & Coinsurance
Mammography One baseline screening for female 35 through 39 years of age One screening mammogram every Calendar Year for female 40 and older Note: or more frequently if recommended by the woman's Physician (M.D.)	\$0 Co-pay	Deductible & Coinsurance
Immunizations and Vaccinations includes those needed for travel	\$0 Co-pay	Deductible & Coinsurance

Vision Exams 1 vision exam and refraction every 12 Months	\$0 Co-pay	Deductible & Coinsurance
Hearing Exams 1 hearing exam every 2 Calendar Years	\$0 Co-pay	Deductible & Coinsurance
HOSPITAL SERVICES		
All Inpatient Admissions [There is a maximum of 3 Per Admission Co-payments per Member per Calendar Year.]	\$100 Co-pay Per Admission	Deductible & Coinsurance
Specialty Hospital 60 days per Covered Person per Calendar Year	\$100 Co-pay Per Admission	Deductible & Coinsurance
Outpatient Surgery In a licensed ambulatory surgical center (including colonoscopy)	\$100 Outpatient Hospital Co-pay	Deductible & Coinsurance
DIAGNOSTIC SERVICES		
Diagnostic, Laboratory and X-ray Services	\$15 Co-pay	Deductible & Coinsurance
High Cost Diagnostic Tests MRI, MRA, CAT, CTA, PET and SPECT scans (\$375 calendar year maximum in co-payments)	\$25 Co-pay	Deductible & Coinsurance
THERAPY SERVICES		
Outpatient Rehabilitation Outpatient rehabilitative and restorative physical, occupational and chiropractic therapy Limited to 50 combined visits per Calendar Year	\$15 Co-pay	Deductible & Coinsurance
Speech Therapy Limited to 30 visits per Calendar Year	\$15 Co-pay	Deductible & Coinsurance
Other Therapy Services: Outpatient cardiac rehabilitation therapy Radiation therapy: Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a Hospital or freestanding dialysis center	\$0 Co-pay	Deductible & Coinsurance

Allergy Office Visit/Testing	\$15 Co-pay	Deductible & Coinsurance
Allergy Injections	\$0 Co-pay for Allergy Injection	Deductible & Coinsurance
Immunotherapy or other therapy treatments		
Up to a maximum of 30 visits per Calendar Year period		

MEDICAL EMERGENCY / URGENT CARE SERVICES

Emergency Room Treatment	\$50 Co-pay	\$50 Co-pay
Emergency Room Copayment waived if the Covered Person is admitted directly to the Hospital from the emergency room		
Urgent Care Services	\$25 Co-pay	\$25 Co-pay

Ambulance	\$0 Co-pay	\$0 Co-pay
Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule.		

PHYSICIAN MEDICAL/ SURGICAL SERVICES

Physician Office Visit	\$15 Co-pay	Deductible & Coinsurance
Specialist Office Visit	\$25 Co-pay	Deductible & Coinsurance
Services of a Physician or Surgeon (other than a medical office visit)	\$0 Co-pay	Deductible & Coinsurance

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Outpatient Treatment for Mental Health Care and Substance Abuse Care	\$15 Co-pay	Deductible & Coinsurance
Inpatient Hospital Services	\$100 Co-pay	Deductible & Coinsurance
In a Hospital or Residential Treatment Center for Mental Health Care Per Admission		
Inpatient Rehabilitation Treatment for Substance Abuse Care	\$100 Co-pay	Deductible & Coinsurance
In a Hospital or Substance Abuse Treatment Facility Per Admission		

OTHER MEDICAL SERVICES

Skilled Nursing Facility up to 120 days per Calendar Year	\$100 Co-pay	Deductible & Coinsurance
Private Duty Nursing limited to \$15,000 Per Calendar Year	No Cost Share	Deductible & Coinsurance
Human Organ and Tissue Transplant Service \$1,000,000 Lifetime Maximum	\$0 Co-pay	Deductible & Coinsurance

Home Health Care Nursing and therapeutic services limited to 200 visits	\$0 Co-pay	\$50 Deductible & 20% Coinsurance
Home health aide services limited to 80 visits that are applicable to the 200 visit limit		
Infusion Therapy Unlimited	\$0 Co-pay	Deductible & Coinsurance
Durable Medical Equipment and Prosthetic Devices Unlimited maximum per Covered Person per Calendar Year	\$0 Cost Share	Deductible & Coinsurance
Hearing Aid Coverage Available for dependent children age 12 years and under with a maximum of \$1,000 within a two year period.		
Ostomy Related Services	\$0 Co-pay	Deductible & Coinsurance
Wig Up to \$350 maximum per Covered Person per Calendar Year.	\$0 Co-pay	No Cost Share
Specialized Formula	\$0 Co-pay	Deductible & Coinsurance
Hospice Care (inpatient) 60 days per Calendar Year	\$0 Co-pay	Deductible & Coinsurance
Infertility Services State Mandate		
Office Visit	\$15 Co-pay	Deductible & Coinsurance
Outpatient Hospital	\$100 Co-pay	Deductible & Coinsurance
Inpatient Hospital	\$100 Co-pay	Deductible & Coinsurance
Infertility Drugs The maximum supply of a drug for which benefits will be provided when dispensed under any on e prescription is 30 day supply or 100 unit dose, whichever is greater Note: If this certificate has a Prescription Drug rider, see rider for infertility drug coverage. Infertility drugs will not apply to the Prescription Drug Rider Maximum. In the absence of a prescription drug rider then the coverage stated in this Schedule of Benefits will apply.	Paid as Out-of-Network	Deductible & Coinsurance

Maternity

\$15 Co-pay
Initial visit only

Deductible & Coinsurance

OTHER

Penalty for Failure to Prior Authorize
Covered Services

\$200 Hospital
and
25% Physician
of Maximum Allowable Amount (MAA)

\$200 Hospital
and
25% Physician
of Maximum Allowable Amount (MAA)

Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than \$500

Pre-Existing Condition Limitation Exclusion – For Late Enrollees cover charges for Pre-Existing Conditions diagnosed or treated during the 6 months immediately preceding the original Effective Date of continuous coverage during the Pre-Existing Condition Limitation Period are not covered. The Pre-Existing Condition Limitation Period may last up to 12 months from your Enrollment Date. Credit from prior Creditable Coverage will be applied if applicable to reduce your specific Pre-Existing Condition Limitation Period.

Note: Out of Network services applicable after Deductible and Coinsurance. The Covered Person is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.