

## Point of Service (Open Access)

# SCHOOLCARE SUMMARY OF BENEFITS

Benefits outlined below are intended only as a general summary. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this summary and the actual provisions of the plan, the provisions as defined in the Health Benefits Booklet and Endorsements will govern. Covered benefits are subject to review for medical necessity. Out of network payments to providers are based on reasonable and customary charges. Subscriber is responsible for charges above reasonable and customary. Plan year is defined from July 1 through June 30.

BENEFITS	Open Access Point of Service (In Network; No Referrals Necessary)	Open Access Point of Service (Out of Network)
<b>DEDUCTIBLES, MAXIMUMS</b>  Annual Deductible Out-of-Pocket Maximum per plan year Maximum Lifetime benefit	A POS MEMBER PAYS  N/A N/A Unlimited	A POS MEMBER PAYS  \$300/person; \$600/family per plan year \$900/person; \$1,800/family per plan year \$1,000,000 per person
<b>PREVENTIVE CARE</b> Routine Physical Examination Routine Childhood Immunizations Well Child Care Routine Gynecological Exam (one per plan year) Mammograms Prostate Cancer Screening	\$10 per visit \$0 \$10 per visit \$10 per visit \$0 \$0	Not Covered Deductible, then 20% to the max. Not Covered Deductible, then 20% to the max. Deductible, then 20% to the max. Deductible, then 20% to the max.
<b>ROUTINE VISION CARE</b> Routine Exam (one per plan year for all ages) Discounts Available for Eyewear	\$10 per visit	Not Covered
<b>HEARING TESTS</b> (covered under PCP to age 19)	\$10 per visit	Not Covered
<b>OTHER PHYSICIAN SERVICES</b> Office Visits and/or Office Surgery Maternity Care	\$10 per visit \$10 per visit (initial visit only)	Deductible, then 20% to the max. Deductible, then 20% to the max.
<b>OUTPATIENT DIAGNOSTIC TESTING</b> Radiology and Laboratory Services	\$0 (Some tests require prior authorization.)	Deductible, then 20% to the max. (Some tests require prior authorization.)
<b>HOSPITAL CARE</b> Inpatient Services Same Day or Outpatient Surgery Radiation and Chemotherapy Physician Visits and Services Anesthesiologist Services Operating Room X-ray and Laboratory Services Medications and Supplies Newborn Care	\$0 (Inpatient admissions and some outpatient procedures require prior authorization.)	Deductible, then 20% to the max. (Inpatient admissions and some outpatient procedures require prior authorization.)
<b>EMERGENCY ROOM CARE</b> <i>(Medically Necessary and Worldwide)</i>	\$50 per visit (waived if admitted)	\$50 per visit (waived if admitted)

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BENEFITS	Open Access Point of Service (In Network; No Referrals Necessary)	Open Access Point of Service (Out of Network)
MENTAL HEALTH/SUBSTANCE ABUSE OUTPATIENT INPATIENT DRUG/ALCOHOL ABUSE <i>(diagnosis, detox, rehab, and medical treatment)</i>	A POS MEMBER PAYS  \$10 copay per visit \$0 (prior authorization required)  \$0 (prior authorization required)	A POS MEMBER PAYS  Deductible, then 20% to the max. (prior authorization required for inpatient admissions)
PRESCRIPTION DRUGS Through participating pharmacies	\$5 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs. Maintenance (90 day supply) available only through mail order for one copay.  (prior authorization required for some drugs)	Through participating pharmacies. See previous column.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES  OUTPATIENT: short-term rehab, up to 60 visits per person/per plan year; includes PT, OT, ST and cardiac rehab (combined maximum in and out of network)  INPATIENT	\$10 per visit  \$0 (prior authorization required)	Deductible, then 20% to the max.  Deductible, then 20% to the max.
CHIROPRACTIC CARE 20 visits per person/per plan year; combined max. in and out of network	\$10 per visit	Deductible, then 20% to the max.
ACUPUNCTURE* 12 visits per person/per plan year; combined max. in and out of network <i>*Coverage based on CIGNA's medical guidelines.</i>	\$10 per visit (reimbursement limited to \$75 per visit)	Deductible, then 20% to the max. (reimbursement subject to reasonable and customary charges)
DURABLE MEDICAL EQUIPMENT \$5,000 maximum/per person/per plan year	20%	Deductible, then 20% to the max.
EXTERNAL PROSTHETIC APPLIANCES \$10,000 maximum/per person/per plan year	20%	Deductible, then 20% to the max.
OTHER BENEFITS ORAL SURGERY <i>(accidents only)</i> REMOVAL OF BONEY IMPACTED WISDOM TEETH SKILLED NURSING CARE <i>(100 days maximum per person/per plan year)</i> AMBULANCE <i>(if medically necessary)</i> BLOOD TRANSFUSIONS HOME HEALTH SERVICES HOSPICE	\$0 \$0 \$0 \$0 \$0 \$0 \$0	All other covered services subject to plan year deductible and 20% coinsurance to the out-of-pocket maximum for the plan year.  (limited to 40 visits per person/per plan year)
<b>GOOD FOR YOU!</b> BY SCHOOLCARE Health and Wellness Incentives, Employee Assistance Program	Covered	Covered