MODULAR DEVICES BENEFIT SUMMARY

GENERAL CONDITIONS

Lifetime Maximum Benefit (per person)	Unlimited
Annual Maximum Benefit (per person)	Unlimited

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Deductible	N/A	$1,000 per individual; $2,500 family
Maximum Out-of-Pocket Expense	N/A	$2,000 per individual; $5,000 family

HOSPITAL SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Hospital Inpatient Services Including Maternity care and Newborn care from birth on *Precertification required- penalty $200 and $100 per day that is not medically necessary*	$500 Co-pay per inpatient stay	10% of billed charges to annual inpatient/ outpatient combined coinsurance maximum of $1,500 yourself/$1,500 Spouse/$1,500 children combined
Hospital Outpatient Services	$75 Co-pay	10% of billed charges or $75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of $1,500 yourself/$1,500 Spouse/$1,500 children combined
Ambulatory Surgical Center	$75 Co-pay	80% of R&C after deductible
Emergency Room The symptoms of an emergency condition (e.g. severe pain) must be serious enough that a layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated; • The person's health, or, in the case of a behavioral condition the person's health or the health of others, could reasonably be in danger; • The person's bodily functions could be seriously impaired • One of the organs or other parts of the body could be harmed; or • The person could be seriously disfigured	$75 Co-pay	100% of covered expenses less $75
Emergency Room Physicians	Covered in Full	80% of R&C after deductible

R&C = Reasonable and Customary

MODULAR DEVICES BENEFIT SUMMARY

HOSPITAL SERVICES (CONT.)

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Pre-Admission Testing *(within 14 days of surgery)*	Covered in Full	100% of covered expenses
Laboratory Service	$75 Co-pay	10% of billed charges or $75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of $1,500 yourself/$1,500 Spouse/$1,500 children combined
Physical Therapy (Inpatient Only)	Covered in Full	Not Covered
Physical Therapy (Outpatient)	$25 Co-pay	10% of billed charges or $75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of $1,500 yourself/$1,500 Spouse/$1,500 children combined
Chemotherapy/Hemodialysis	Covered in Full	10% of billed charges or $75 (whichever is greater) up to a combined annual inpatient/ outpatient combined coinsurance maximum of $1,500 yourself/$1,500 Spouse/$1,500 children combined

PHYSICIAN SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Physician Office Visits	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of R&C after deductible
Specialist Office Visits	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of R&C after deductible
Gynecology Office Visits	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of R&C after deductible
Diagnostic Tests & X-Ray	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of R&C after deductible

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MODULAR DEVICES BENEFIT SUMMARY

PHYSICIAN SERVICES (Cont.)

Laboratory Services (including freestanding labs)	$30 Co-pay per date of service	80% of R&C after deductible
Well Baby/Child Care (up to age 18) (Including Immunizations) (Gardisil is covered for male & female ages 19-26)	Covered in Full	Not Covered
Routine Adult Physical Exam	$25 Co-pay per date of service per type of procedure. Max 2 copays	Not Covered
Surgery	$25 Co-pay per date of service per type of procedure. Max 2 copays $15 Co-pay at a freestanding ambulatory surgery facility	80% of R&C after deductible
Anesthesiology	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of R&C after deductible
Maternity	Covered in Full	80% of R&C after deductible
Newborn Care	Covered in Full	100% of R&C Maximum benefit $150
Allergy Testing	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of R&C after deductible
Allergy Treatment	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of R&C after deductible
Chiropractic Services *Requires prior authorization* Modalities not covered	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of R&C after deductible
Physical, Occupational & Speech Therapy 60 visits per year maximum *Requires prior authorization* *Must start 6 months from hospital discharge or surgery.* *No payments made after 365 days from the date of discharge or surgery*	$25 Co-pay per date of service per type of procedure. Max 2 copays	Not Covered
Durable Medical Equipment $1,000 per year maximum *Requires prior authorization*	Covered in Full After 10% Co-pay	Not Covered

R&C = Reasonable and Customary

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MODULAR DEVICES BENEFIT SUMMARY

MENTAL HEALTH / SUBSTANCE ABUSE SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Substance Abuse Inpatient 30 days per calendar year maximum 2 stays per lifetime	$500 Co-pay per inpatient stay *Pre-Certification of the admission is required*	Not Covered
Substance Abuse Outpatient 60 visits per year maximum 20 family visits per year maximum	$25 Co-pay per date of service per type of procedure. Max 2 copays	Not Covered
Mental Health Inpatient	$500 Co-pay per inpatient stay *Pre-Certification of the admission is required*	90% of billed charges: 100% after $500 inpatient mental health coinsurance
Mental Health Outpatient	$25 Co-pay per date of service per type of procedure. Max 2 copays	80% of covered expense after $350 outpatient mental health deductible

OTHER BENEFITS

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Infertility Treatment	Not Covered	Not Covered
Hospice Care *Pre-Certification is required*	Covered in Full 90 day maximum	Not Covered
Skilled Nursing Facility *Pre-Certification is required* Retirees who have Medicare primary are not eligible to receive benefits	Covered in Full 40 days per calendar year maximum	Not Covered
Home Health Care *Pre-Certification is required* Custodial Care is not covered	Covered in Full 60 visits per calendar year maximum	Not Covered
Diabetic Supplies	Covered in Full	50% of allowable amount after deductible
Ambulance	$35 Co-pay	$35 Co-pay *Volunteer ambulance covered in full up to $50 under 50 miles and $75 over 50 miles*
Hearing Aid	Not Covered	Not Covered

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MODULAR DEVICES BENEFIT SUMMARY

PRESCRIPTION DRUGS

Prescription Drug Benefit

Up to 30 day supply at retail or mail order pharmacy	Generic Drugs	$12
	Preferred Brand Name Drugs	$25
	Non-Preferred Brand Name Drugs	$60 plus the difference between the Generic and Brand
31-90 day supply at retail pharmacy	Generic Drugs	$15
	Preferred Brand Name Drugs	$40
	Non-Preferred Brand Name Drugs	$75 plus the difference between the Generic and Brand
31-90 day supply at mail order pharmacy	Generic Drugs	$10
	Preferred Brand Name Drugs	$20
	Non-Preferred Brand Name Drugs	$55 plus the difference between the Generic and Brand