APPENDIX B

MEDICAL SCHEDULE OF BENEFITS

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single Family	$100 $300	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (excludes Deductible and Prescription Drug Copays)		
Per Covered Person	$488	
MEDICAL BENEFITS		
Ambulance Services	90% after Deductible	90% after Deductible
Emergency Room Services - Medical Emergency	90% after Deductible	90% after Deductible
Emergency Room Services - Non-Medical Emergency	90% after Deductible	75% after Deductible
Home Health Care	90% after Deductible	90% after Deductible
Calendar Year Maximum Benefit	130 visits	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	90% after Deductible	75% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	90% after Deductible	75% after Deductible
Outpatient	90% after Deductible	75% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Mental Disorders and Substance Use Disorders		
Inpatient: Facility Professional/Ancillary Fees	 90% after Deductible 90% after Deductible	 75% after Deductible 90% after Deductible
Outpatient: Facility Professional/Ancillary Fees	 90% after Deductible 90% after Deductible	 75% after Deductible 90% after Deductible
NOTE: Emergency care (ambulance and emergency room) will be paid the same as the benefits for ambulance services and emergency room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Physician's Services		
Inpatient/Outpatient Services	90% after Deductible	90% after Deductible
Office Visits	90% after Deductible	90% after Deductible
Physician Office Surgery	90% after Deductible	90% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Routine Care		
Routine Colonoscopy Age 50 And Over	90% after Deductible	90% after Deductible
Calendar Year Maximum Benefit	1 colonoscopy	
Routine Immunizations	90% after Deductible	90% after Deductible
Routine Mammogram	90% after Deductible	90% after Deductible
Calendar Year Maximum Benefit*	1 mammogram	
*This limit does not apply for a Covered Person with a history of breast cancer; or whose parent or sibling has a history of breast cancer, then as recommend by a Physician.		
Routine Pap Smear, Including Charges Associated With Office Visit	90% after Deductible	90% after Deductible
Calendar Year Maximum Benefit	1 exam	
Routine Prostate Cancer Screening Test, Including PSA**	90% after Deductible	90% after Deductible
Calendar Year Maximum Benefit	1 test	
**This benefit applies to Covered Persons who are (a) at least 35 years of age but less than 40 years of age and the person is in a high risk group. For purposes of this provision, "high risk" means a person who is an African-American or who has a family history of prostate cancer; or (b) 40 or more years of age.		
Surgical Procedures (BridgeHealth Surgery Benefit)	100%; Deductible waived	N/A
NOTE: Certain Surgical Procedures are covered at 100% (Deductible waived) when they are received through the BridgeHealth Surgery Benefit option. Not all Surgical Procedures are eligible for coverage under this option. Please refer to the BridgeHealth Surgery Benefit section for a more detailed description of this benefit.		
Transplants (Facility)	90% after Deductible (Aetna IOE Program)* 75% after Deductible (All Other Network Providers)	75% after Deductible
Donor Expenses Maximum Benefit Per Transplant	N/A	$20,000
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
All Other Eligible Medical Expenses	90% after Deductible	90% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
Retail Pharmacy: 90-day supply or 100 unit dose	
Generic Drug	$5 Copay
Brand Name Drug	$10 Copay
Mail Order Pharmacy: 90-day supply or 100 unit dose	
Generic Drug	$5 Copay
Brand Name Drug	$10 Copay