MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD 2015-2016

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$300	$1,200
Family	$900	$3,600
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance, medical Copays and Precertification Penalties – combined with Prescription Drug Card)		
Single	$4,000	N/A
Family	$8,000	N/A
MEDICAL BENEFITS		
Allergy Serum & Injections		
Injections (If no office visit charge)	100% after $5 Copay per visit; Deductible waived	50% after Deductible
Serum	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Ambulance Services		
Ground	85% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance	$200 Copay per trip, then 85% after Deductible	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	85% after Deductible	50% after Deductible
Anesthesiologist	85% after Deductible	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	$50 Copay per pair, then 85%; Deductible waived	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs	
Cardiac Rehab (Outpatient)	100% after $20 Copay per visit; Deductible waived	50% after Deductible
Chemotherapy (Outpatient)	85% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	100% after $20 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 Visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Any Single Service Costing Less Than $500	85% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	85% after Deductible	50% after Deductible
Freestanding Laboratory	100% after $20 Copay; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	85% after Deductible	50% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Durable Medical Equipment (DME)	85% after Deductible	50% after Deductible
Emergency Services		
Emergency Medical Condition		
Facility Charges	85% after Deductible	Paid at Participating Provider level of benefits, unless otherwise required by law
Professional Fees and Ancillary Charges	85% after Deductible	Paid at Participating Provider level of benefits, unless otherwise required by law
Non-Emergency Medical Condition		
Facility Charges	85% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	85% after Deductible	50% after Deductible
Foot Orthotics	$50 Copay per orthotic, then 85%; Deductible waived	$50 Copay per orthotic, then 50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months	
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	85% after Deductible	$50 Copay, then 50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
Hemodialysis (Outpatient)	85% after Deductible	50% after Deductible
Home Health Care	85% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*	
*Home health care supplies are not subject to the Calendar Year Maximum.		
Hospice Care		
Inpatient	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	85% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	85% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.		
Infusion Therapy in Facility or Physician's Office	85% after Deductible	50% after Deductible

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	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	85% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Medical Supplies	85% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility Charge	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Fees	85% after Deductible	50% after Deductible
Outpatient Facility	85% after Deductible	50% after Deductible
Office Visits		
Primary Care Physician	100% after $20 Copay; Deductible waived	50% after Deductible
Specialist	100% after $30 Copay; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Morbid Obesity (Surgical Treatment Only)		
Facility (Inpatient and outpatient)	$250 Copay, then 85%; Deductible waived	50% after Deductible
Professional Services	85% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Food Supplements	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	100% after $20 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Physical Therapy (Outpatient)	100% after $20 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Physician's Services		
Inpatient/Outpatient Services		
Primary Care Physician	85% after Deductible	50% after Deductible
Specialist	85% after Deductible	50% after Deductible

MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD 2015-2016

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Office Visits		
Primary Care Physician	100% after $20 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $30 Copay*; Deductible waived	50% after Deductible
Physician Office Surgery		
Primary Care Physician	Under $1,000 - 100% after $20 Copay*; Deductible waived; $1,000 or more – 85% after Deductible	50% after Deductible
Specialist	Under $1,000 - 100% after $30 Copay*; Deductible waived; $1,000 or more – 85% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% up to $300 per Calendar Year, then 10%; Deductible waived	Not Covered
Flu Shots/Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	100% after $20 Copay per exam; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam	
Prosthetics (other than bras)	85% after Deductible	50% after Deductible
Prosthetic Bras	85% after Deductible	85% after Deductible
Calendar Year Maximum Benefit	2 bras	
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient)	85% after Deductible	50% after Deductible
Rehabilitation Facility	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days	
Skilled Nursing Facility	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days	

MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD 2015-2016

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Speech Therapy (Outpatient)	100% after $20 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Surgery (Inpatient)		
Facility	$250 Copay per admission, then 85%; Deductible waived	50% after Deductible
Professional Services	85% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include surgery in the Physician's office)		
Facility	85% after Deductible	50% after Deductible
Professional Services	85% after Deductible	50% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	$50 Copay per occurrence, then 85%; Deductible waived	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000	
Transplants(Facility)	$250 Copay per admission, then 85%; Deductible waived	Not Covered
Urgent Care Facility	$50 Copay per visit, then 85%; Deductible waived	$50 Copay per visit, then 50% after Deductible
Wig (see Eligible Medical Expenses)	$50 Copay per wig, then 85%; Deductible waived	$50 Copay per wig, then 85%; Deductible waived
Maximum Benefit per 24 Month Period	1 wig	
All Other Eligible Medical Expenses	$50 Copay*, then 85%; Deductible waived	$50 Copay*, then 50% after Deductible

*Copay applies per eligible item, service or occurrence.

PRESCRIPTION SCHEDULE OF BENEFITS – CLASSIC GOLD 2015-2016

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical) Single Family	 $4,000 $8,000
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	30% Copay ($40 minimum, $110 maximum)
Specialty Drug	20% Copay ($100 minimum, $150 maximum)
Preventive Drug	$0 Copay (100% paid)
Diabetic Medications Generic Brand Name (Covered Persons must enroll in the Catamaran Diabetic Sense Program to receive the Copay for their diabetic supplies)	 $5 Copay $10 Copay
Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	30% Copay ($80 minimum, $225 maximum)
Preventive Drug	$0 Copay (100% paid)
Diabetic Medications Generic Brand Name (Covered Persons must enroll in the Catamaran Diabetic Sense Program to receive the Copay for their diabetic supplies)	 $10 Copay $30 Copay

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The Covered Person's share of the Prescription Drug cost does not apply toward the Plan's Out-of-Pocket Maximum.