

SCHEDULE OF BENEFITS PPI – Group ID JE882

This chart shows what the Plan pays. All benefits are subject to the deductible except where noted otherwise.

See Rules and Regulations in this booklet for more information.

Benefit Description	Explanation and Limitations	PPO Providers (In-Network)	Non-PPO Providers (Out of Network)
Ambulance	<ul style="list-style-type: none"> • Air • Surface 	80%	80%
Ambulatory/Surgery Facility	<ul style="list-style-type: none"> • Hospital-based or Free standing outpatient surgery center • Deductible waived 	80%	60%
Anesthesia		80%	60%
Assistant Surgeons	<ul style="list-style-type: none"> • 20 % of Surgeons Allowable 	80%	60%
Convalescent Rehab Facility	<ul style="list-style-type: none"> • Paid like any other Hospital 	80%	60%
Chemotherapy		80%	60%
Chiropractic Care	<ul style="list-style-type: none"> • Musculoskeletal Therapy 	80%	80%
Cosmetic Surgery	<ul style="list-style-type: none"> • Only for repair of damage resulting from an accident & incurred within 1 year from date of injury 	80%	60%
Death Benefits – Accidental Death & Dismemberment – Employee Only	<ul style="list-style-type: none"> • \$5000.00 		
Death Benefits – Employee Only	<ul style="list-style-type: none"> • \$5000.00 		
Deductible • Per calendar year	<ul style="list-style-type: none"> • \$350.00 per person • \$700.00 per family 		
Dental/Orthodontic	<ul style="list-style-type: none"> • No Benefit 		
Disability Benefits	<ul style="list-style-type: none"> • No Benefit 		
Durable Medical Equipment (DME)	<ul style="list-style-type: none"> • Charges for rental of wheelchair, Hospital Bed and other durable medical equipment, but not to exceed the purchase of such equipment. 	80%	60%
Emergency Room (ER)		80%	80%
Experimental Treatment	Vax-D, IDD and any other experimental treatment is not covered.	0%	0%
Hearing Benefit	<ul style="list-style-type: none"> • Exams: One during a period of 3 consecutive calendar years • Exams and Hearing aids Subject to deductible • Hearing Aids: Max \$500.00 per ear, during a period of 3 consecutive calendar years 	80%	60%

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Home Health Care	<ul style="list-style-type: none"> ▪ Not for custodial care. ▪ Approval must be obtained by Trustmark 	80%	60%
Hospice Care		80%	60%
Hospital - Inpatient <ul style="list-style-type: none"> • Pre-cert Mandatory • Failure to pre-cert \$100.00 penalty 	<ul style="list-style-type: none"> • 90% Point of Service Hospital • Contact CHOICE for pre-cert 602-417-2300 or 1-800-852-8001 	80%	60%
Hospital – Other Charges		80%	60%
Infertility		80%	60%
Lifetime Max	<ul style="list-style-type: none"> • \$1,000,000.00 		
Maternity	<ul style="list-style-type: none"> • Initial visit included in global fee • Maternity charges are paid @global rate at time of delivery • Lab charges, ultrasound or non-fetal stress test not included in global charges 	80%	60%
Mammograms	<ul style="list-style-type: none"> • For screening or diagnostic purposes • One routine mammogram age 35-40 • One every two years age 40-49 • One a year age 50 & up (annual) 	80%	60%
Newborn Care	<ul style="list-style-type: none"> • Routine newborn nursery care • Physician initial exam while in the nursery is covered like any other illness 	80%	60%
Orthotics	<ul style="list-style-type: none"> • Charges for prescribed orthopedic shoes and other supportive appliance • Shall not exceed \$300 during any period of 24 consecutive months • No coverage for non-surgical treatment of feet 	80%	60%
Physician And Health Care Practitioner Office Services	<ul style="list-style-type: none"> • Office Ancillary Charges paid the same 	80%	60%
Physical Exam	<ul style="list-style-type: none"> • No benefit 	N/A	N/A

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Physical, Occupational & Osteopathic Manipulative Therapy	<ul style="list-style-type: none"> Payable when rendered by a Registered Physical Therapist or a Registered Occupational Therapist Prescription for frequency and duration required by a Physician 	80%	60%
Pre-Existing	<ul style="list-style-type: none"> Non-jobsite Class participants – no benefits payable. Jobsite Class participants – does not apply. 		
Prescription Drugs (Outpatient) <u>Effective 07-01-10</u> CVS/Caremark 877-876-7217	<ul style="list-style-type: none"> CVS/Caremark 1-877-876-7217 (effective 07-01-10) <ul style="list-style-type: none"> Covered charges for medication (including oral contraceptive) Mail order. Medicines dispensed at a network pharmacy will be discounted at time of purchase. 		
Prosthetic Appliances	<ul style="list-style-type: none"> Items replacing a missing body part, such as an artificial limb Prescription of medical necessity required Replacement of prosthetic devices not covered 	80%	60%
Lasik (RK)		80%	60%
Routine Pap/Physicals	<ul style="list-style-type: none"> No Benefit 		
Smoking Cessation	<ul style="list-style-type: none"> No Benefit 		
Second/Third Surgical Opinion	<ul style="list-style-type: none"> Second/Third Surgical opinion Deductible does not apply In-Network Providers only. 	100%	Does not apply
Surgeons		80%	60%
Timely Filing	<ul style="list-style-type: none"> 15 months 		
TMJ (Temporo-mandibular joint dysfunction)	<ul style="list-style-type: none"> For Medical procedures only. 	80%	60%
Well Child Care (Under age 19)	<ul style="list-style-type: none"> Calendar Year Maximum \$500.00 Subject to Deductible Includes Physical exam, checkups, x-rays & lab, immunizations 	80%	60%
All Other Covered Charges		80%	60%

In Network



Secondary Wrap Network



SCHEDULE OF BEHAVIORAL HEALTH BENEFITS PPI

See Rules and Regulations in this booklet for more information.

Substance Abuse - Inpatient Care	<ul style="list-style-type: none">• 30 days per calendar year• Lifetime max of 60 days• No more than 1 full course of inpatient treatment, or 30 days of confinement, in any 36 month period• No more than 2 full courses of inpatient treatment or 60 days of confinement during insured's lifetime• Charges for treatment of substance abuse are covered only if the insured completed the full course of treatment• Benefits are payable at 80% for ppo providers and 60% for non ppo providers but shall not exceed \$7,500.00 any calendar year & \$15,000.00 during a lifetime
Substance Abuse - Outpatient Care	<ul style="list-style-type: none">• 50% payable to \$7,500.00 calendar year maximum
Mental Health - Inpatient Care	<ul style="list-style-type: none">• Paid the same as any other illness
Mental Health - Outpatient Care	<ul style="list-style-type: none">• 50 % for Maximum of 50 visits per calendar year

SCHEDULE OF VISION PLAN BENEFITS PPI

Payable vision services must be obtained from the in-network Vision Care Providers. Contact the Vision Plan for the list of in-network vision providers. Call **SightCare 480-961-1702**

SERVICE	Nationwide Vision Network (EPN)	SightCare Doctor Network (PPN)	Out of Network Allowance
Eye Exam One exam every 12 months	\$10 Copay	\$10 Copay	\$36
Contact Lens Fitting Fee	100% covered	See Contact Lenses	See Contact Lenses
Frames – Material	\$10 copay	\$10 copay	\$31
Frames – Allowance	Up to \$60	Up to \$60	
Single Vision Lenses	100% covered	100% covered	\$25
Bifocal Lenses	100% covered	100% covered	\$41
Trifocal Lenses	100% covered	100% covered	\$53
Lenticular Lenses	100% covered	100% covered	\$100
Progressive Lenses	\$30 copay	20% discount	\$41
Polycarbonate Under 18 years of age	100%	20% discount	Not Covered
Lens Options	20% discount	20% discount	Not Covered
Contact Lenses – Product Allowance In lieu of Exam, Eyeglasses (frames & lenses)	\$10 material copay	\$60 allowance towards lenses and fitting	\$60 allowance towards lenses and fitting