

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%
Annual Calendar Yr Max	<ul style="list-style-type: none"> \$1,250,000.00 (Effective 01-01-11) 		
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 Subject to deductible 	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 (Effective 01-01-11) 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	Lifetime Max No Longer Applies See Annual Calendar Yr Maximum (Effective 01-01-11)		
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%
Musculoskeletal Therapy	<ul style="list-style-type: none"> Charges incurred for therapy involving manual manipulation of the musculoskeletal system (Effective 01-01-11) 	80%	
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%

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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
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"> No pre-existing condition limitations for members under the age 19(Effective 01-01-11) Non-jobsite Class participants – no benefits payable. Jobsite Class participants – does not apply. 		
Prescription Drugs (Outpatient)	<ul style="list-style-type: none"> CVS/Caremark 1-877-876-7217 Covered charges for medication (including oral contraceptive) 80% to a max of \$100.00 per retail prescription and a max of \$200 per mail order prescriptions (Effective 01-01-11) <ul style="list-style-type: none"> Mail order 80% to a max of \$200 per mail order prescriptions (Effective 01-01-11) 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. Subject to deductible 	80%	60%

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Well Child Care (Under age 19)	<ul style="list-style-type: none"> • 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.

Benefit Description	Explanation and Limitations	PPO Providers (In-Network)	Non-PPO Providers (Out of Network)
Substance Abuse - Inpatient Care	<ul style="list-style-type: none"> • Subject to Major Medical Deductibles (Effective 01-01-11) 	80%	60%
Substance Abuse - Outpatient Care	<ul style="list-style-type: none"> • Subject to Major Medical Deductibles (Effective 01-01-11) 	80%	60%
Mental Health - Inpatient Care	<ul style="list-style-type: none"> • Subject to Major Medical Deductibles (Effective 01-01-11) 	80%	60%
Mental Health - Outpatient Care	<ul style="list-style-type: none"> • Subject to Major Medical Deductibles (Effective 01-01-11) 	80%	60%

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