

SCHEDULE OF BENEFITS - MEDICAL - PLAN MSPTA

All benefits are subject to the Policy Maximums, Deductibles, Co-Insurance, General Exclusions and other applicable limitations. Benefit percentages and amounts are based on Covered Expenses. All benefits are payable only for Medically Necessary services, supplies, and treatment. Please refer to the provisions in the Certificate of Insurance for a complete description of coverages, exclusions and limitations.

	IN-NETWORK	OUT-OF-NETWORK
Deductible	None	\$100 per person \$200 per family
Annual Coinsurance maximum (does not include Deductible or Copays)	\$500 per person	\$1,000 per person
Copay (Does not apply to Coinsurance maximum)	Per Service. Amount as indicated.	
Lifetime Maximum, All Benefits Combined	\$2,000,000	
	IN-NETWORK	OUT-OF-NETWORK (after Deductible unless waived)
PREVENTIVE SERVICES		
Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures (one per Calendar Year)	100% of Covered Expenses	100% of Covered Expenses (Deductible waived)
Annual Gynecological Exam (one per Calendar Year)	100% of Covered Expenses	100% of Covered Expenses (Deductible waived)
Well-Baby Care	100% of Covered Expenses after \$5 Copay	80% of Covered Expenses (Deductible waived)
Well Child Care	100% of Covered Expenses after \$5 Copay	80% of Covered Expenses (Deductible waived)
Immunizations	100% of Covered Expenses	80% of Covered Expenses (Deductible waived)
Mammography Screening (over age 35) (one per Calendar Year)	100% of Covered Expenses	80% of Covered Expenses
Pap Smear Screening - - laboratory services only (one per Calendar Year)	100% of Covered Expenses	80% of Covered Expenses
Fecal Occult Blood Screening	100% of Covered Expenses	100% of Covered Expenses
Prostate Specific Antigen (PSA) Screening	100% of Covered Expenses	100% of Covered Expenses
Flexible Sigmoidoscopy Exam or Colonoscopy	100% of Covered Expenses	80% of Covered Expenses
Nutritional Education and Counseling	Not Covered	Not Covered
Health Education and Counseling (Limited Benefits)	100% of Covered Expenses	80% of Covered Expenses
OTHER SERVICES		
Contraceptives: Devices, Injections	Not Covered	Not Covered
Contraceptives: IUD's	100% of Covered Expenses	80% of Covered Expenses
Infertility Counseling/Treatment (Limited Benefits)	100% of Covered Expenses	80% of Covered Expenses

	IN-NETWORK	OUT-OF-NETWORK (after Deductible unless waived)
ROUTINE MEDICAL SERVICES (for other than Mental Health Care and Alcoholism and Substance Abuse Care)		
Routine Office Visits	100% of Covered Expenses after \$5 Copay	80% of Covered Expenses
Consulting Specialist Care (when necessary)	100% of Covered Expenses after \$5 Copay	80% of Covered Expenses
Allergy Testing and Therapy	100% of Covered Expenses	80% of Covered Expenses
Outpatient diabetic management program (limitations apply)	100% of Covered Expenses	80% of Covered Expenses
SERVICES IN HOSPITAL (for other than Mental Health Care and Alcoholism and Substance Abuse Care)		
Number of days of care	365 days In and Out-of-Network combined	
Semi-Private Room & Intensive Care	100% of Covered Expenses	80% of Covered Expenses
Ancillary Services	100% of Covered Expenses	80% of Covered Expenses
Facility Charges for Surgery & All Related Surgical Services	100% of Covered Expenses	80% of Covered Expenses
Anesthesia	100% of Covered Expenses	80% of Covered Expenses
Laboratory Tests & X-Rays	100% of Covered Expenses	80% of Covered Expenses
Medicines and Drugs (inpatient only)	100% of Covered Expenses	80% of Covered Expenses
SURGICAL SERVICES - Professional Fees (for other than Mental Health Care and Alcoholism and Substance Abuse Care)		
Surgery – includes related surgical services	100% of Covered Expenses	80% of Covered Expenses
Sterilization	100% of Covered Expenses	80% of Covered Expenses
LASIK Surgery	100% of Covered Expenses	80% of Covered Expenses
Human Organ Transplant Procedures (non-Experimental only)	100% of Covered Expenses	80% of Covered Expenses
EMERGENCY CARE - MEDICAL (for other than Mental Health Care and Alcoholism and Substance Abuse Care)		
Hospital & Physician Services	100% of Covered Expenses	100% of Covered Expenses
Urgent Care Facility	100% of Covered Expenses	100% of Covered Expenses
Ambulance Services	100% of Covered Expenses	100% of Covered Expenses
EMERGENCY CARE - ACCIDENTS (for other than Mental Health Care and Alcoholism and Substance Abuse Care)		
Hospital Emergency Room – approved diagnosis	100% of Covered Expenses	100% of Covered Expenses
Urgent Care Facility	100% of Covered Expenses	100% of Covered Expenses
Ambulance Services	100% of Covered Expenses	100% of Covered Expenses

	IN-NETWORK	OUT-OF-NETWORK (after Deductible unless waived)
MATERNITY SERVICE PROVIDED BY A PHYSICIAN		
Outpatient Pre-Natal and Post-Natal Care	100% of Covered Expenses	80% of Covered Expenses
Delivery in Hospital	100% of Covered Expenses	80% of Covered Expenses
Newborn Baby Care in Hospital	100% of Covered Expenses	80% of Covered Expenses
DIAGNOSTIC & THERAPEUTIC SERVICES (for other than Mental Health Care and Alcoholism and Substance Abuse Care)		
Laboratory and Pathology Tests	100% of Covered Expenses	80% of Covered Expenses
Diagnostic Tests and X-rays	100% of Covered Expenses	80% of Covered Expenses
Radiation Therapy	100% of Covered Expenses	80% of Covered Expenses
ALTERNATIVES TO HOSPITAL CARE (for other than Mental Health Care and Alcoholism and Substance Abuse Care)		
Skilled Nursing Care in a nursing home	100% of Covered Expenses	80% of Covered Expenses
Skilled Nursing Care in a residential home	90% of Covered Expenses	80% of Covered Expenses
Home Health Care	90% of Covered Expenses	80% of Covered Expenses
Custodial Care	Not Covered	Not Covered
Hospice Care	90% of Covered Expenses	80% of Covered Expenses
APPLIANCES & PROSTHETIC DEVICES (LEG BRACES, ARTIFICIAL LIMBS, ETC.)		
When Medically Necessary	90% of Covered Expenses	80% of Covered Expenses
When Body's Growth or Development Necessitates Replacement	90% of Covered Expenses	80% of Covered Expenses
Normal Wear and Damage	Not Covered	Not Covered
Durable Medical Equipment (Wheelchairs, Hospital Beds, Crutches, etc.)	90% of Covered Expenses	80% of Covered Expenses
HEARING SERVICES		
Hearing Screening	100% of Covered Expenses after \$15 Copay;	Not Covered
Hearing Examination Audiology test Covered Expenses with medical diagnosis	100% of Covered Expenses	Not Covered
Hearing Aids	100% of Covered Expenses	Not Covered
SPINAL MANIPULATION SERVICES		
Manipulations or adjustments; diagnostic radiological services; evaluation and treatment (\$1500 limit per Calendar Year, maximum 30 visits per Calendar Year)	100% of Covered Expenses after \$5 Copay;	80% of Covered Expenses

	IN-NETWORK	OUT-OF-NETWORK (after Deductible unless waived)
OTHER SERVICES		
Outpatient Speech Therapy (Maximum 30 visits per Calendar Year)	Physician's Office: 100% of Covered Expenses after \$5 office Copay	80% of Covered Expenses
	Other: 90% of Covered Expenses	
Outpatient Physical Therapy (Maximum 30 visits per Calendar Year)	Physician's Office: 100% of Covered Expenses after \$5 office Copay	80% of Covered Expenses
	Other: 90% of Covered Expenses	
Outpatient Occupational Therapy (Maximum 30 visits per Calendar Year)	Physician's Office: 100% of Covered Expenses after \$5 office Copay	80% of Covered Expenses
	Other: 90% of Covered Expenses	
Private Duty Nursing	90% of Covered Expenses	80% of Covered Expenses

	IN-NETWORK	OUT-OF-NETWORK (after Deductible unless waived)
MENTAL HEALTH CARE		
Outpatient Psychiatric Hospital Services	100% of Covered Expenses after \$5 Copay	80% of Covered Expenses
Inpatient Psychiatric Hospital Services (up to 365 days)	100% of Covered Expenses	80% of Covered Expenses
ALCOHOLISM & DRUG ABUSE CARE		
Outpatient Alcoholism and Drug	100% of Covered Expenses after \$5 Copay	80% of Covered Expenses
Inpatient Alcoholism and Drug (up to 365 days)	100% of Covered Expenses	80% of Covered Expenses