MIAMI TRACE LOCAL SCHOOLS

MEDICAL BENEFITS SCHEDULE
MINIMUM VALUE PLAN

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$5,000	$10,000
Per Family Unit	$10,000	$20,000
The Network Deductible amounts will be combined with the Non-Network Deductible amounts.		
The Calendar Year deductible is waived for the following Covered Charges: - Network Preventive Care		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (including deductibles)		
Per Covered Person	$6,500	$13,000
Per Family Unit	$13,000	$26,000
The Network Out-of-Pocket amounts will be combined with the Non-Network Out-of-Pocket amounts.		
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum: Non-Precertification penalties Amounts over Usual and Reasonable Charges		
COVERED CHARGES		
Inpatient Hospital Services		
Room, Board, and Miscellaneous Expenses	50% after deductible	50% after deductible
Non-Network Inpatient admissions as a result of an emergency will be paid same as In-Network.		
Outpatient Hospital Services		
Surgical Facilities	50% after deductible	50% after deductible
Other Outpatient Services	50% after deductible	50% after deductible
Emergency Room Visit	50% after deductible	Paid same as Network
Ambulance	100% after deductible	50% after deductible
Urgent Care Facility	50% after deductible	50% after deductible
Skilled Nursing Facility	50% after deductible	50% after deductible
Physician Services		
Inpatient visits	50% after deductible	50% after deductible
Office visits	50% aftet deductible	50% after deductible
Surgery	50% after deductible	50% after deductible
Anesthesia	50% after deductible	50% after deductible
Diagnostic Testing (X-ray & Lab)	50% after deductible	50% after deductible
Home Health Care	50% after deductible	50% after deductible
Hospice Care	50% after deductible	50% after deductible
Ambulance Service	50% after deductible	50% after deductible
Mental Disorders/Substance Abuse	Paid based on the type of service(s) received.	

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Preventive Care		
Routine Well Care	100%	50% after deductible
Includes: office visits, pap smear, mammogram, gynecological exam, routine physical examination, x-rays, laboratory tests, prostate specific antigen test, colonoscopies, sigmoidoscopies and anoscopy, proctosigmoidoscopy, medical tests and other preventive services as required by law.		
Other Medical Services and Supplies	50% after deductible	50% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE
MINIMUM VALUE PLAN

PRESCRIPTION DRUG BENEFIT	
	BENEFIT
Pharmacy Option (30 Day Supply)	
Generic Drugs	50%
Preferred Brand Name Drugs	50%
Non-Preferred Brand Name Drugs	50%
Specialty Drugs	50%
Mail Order Option (90 Day Supply)	
Generic Drugs	50%
Preferred Brand Name Drugs	50%
Non-Preferred Brand Name Drugs	50%
Specialty Drugs	50%
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.	

Note: Prescription Drug expenses under the Prescription Drug Program do not apply to the Calendar Year Deductible. Prescription Drug expenses do apply to the Out-of-Pocket Maximum under Medical Benefits section of this Plan.