**MIAMI TRACE LOCAL SCHOOLS**

**MEDICAL BENEFITS SCHEDULE**
**PPO 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.** | | |
| **SUPPLEMENTAL ACCIDENT BENEFIT** | | |
| Within 90 Days of the Accident | $500 per Calendar Year | |
| **DEDUCTIBLE, PER CALENDAR YEAR** | | |
| Per Covered Person | $500 | $1,000 |
| Per Family Unit | $1,000 | $2,000 |
| Amounts applied to the Network Deductible and the Non-Network Deductible do not cross-apply. | | |
| The Calendar Year deductible is waived for the following Covered Charges:<br>- Network Preventive Care<br>- Flu Shot<br>- Network Office visits<br>- Second Surgical Opinion | | |
| **COPAYMENTS** | | |
| Physician visits | $25 | n/a |
| Specialist visits | $50 | n/a |
| Urgent Care Facility | $50 | n/a |
| **MAXIMUM COINSURANCE LIMIT, PER CALENDAR YEAR (includes deductible)** | | |
| Per Covered Person | $1,500 | $3,000 |
| Per Family Unit | $3,000 | $6,000 |
| **MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (including copayments)** | | |
| Per Covered Person | $6,350 | $12,700 |
| Per Family Unit | $12,700 | $25,400 |
| 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:<br>Non-Precertification penalties<br>Amounts over Usual and Reasonable Charges | | |
| **COVERED CHARGES** | | |
| **Inpatient Hospital Services** | | |
| Room, Board, and Miscellaneous Expenses | 80% after deductible | 60% after deductible |
| Intensive Care Unit | 80% after deductible | 60% after deductible |
| **Outpatient Hospital Services** | | |
| Surgical Facilities | 80% after deductible | 60% after deductible |
| Other Outpatient Services | 80% after deductible | 60% after deductible |
| **Emergency Room Visit** (Including related services) | 80% after deductible | Paid Same As Network |
| **Ambulance** | 80% after deductible | Paid Same As Network |
| **Urgent Care Facility** (Including related services) | 80% after deductible and copayment | 60% after deductible |

| | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|
| **Skilled Nursing Facility** | 80% after deductible | 60% after deductible |
| **Physician Services** | | |
| Inpatient visits | 80% after deductible | 60% after deductible |
| Office visits (Office charge only) | 100% after copayment | 60% after deductible |
| Specialist office visits (Office charge only) | 100% after copayment | 60% after deductible |
| Surgery | 80% after deductible | 60% after deductible |
| Anethesia | 80% after deductible | Paid Same As Network |
| Second Surgical Opinion | 100% | Paid Same As Network |
| **Diagnostic Testing (X-ray & Lab)** | 80% after deductible | 60% after deductible |
| Independent Laboratories | 80% after deductible | Paid Same As Network |
| Radiology/Pathology Interpretation | 80% after deductible | Paid Same As Network |
| **Home Health Care/Private Duty Nursing** | 80% after deductible | 60% after deductible |
| **Hospice Care** | 80% after deductible | 60% after deductible |
| Bereavement Counseling | 2 visit Lifetime maximum | 2 visit Lifetime maximum |
| **Jaw Joint/TMJ** (excluding surgery) | 80% after deductible | 60% after deductible |
| **Wig After Chemotherapy** | 80% after deductible<br>$400 Lifetime maximum | 60% after deductible<br>$400 Lifetime maximum |
| **Spinal Manipulation/ Chiropractic** | 80% after deductible<br>15 visit Calendar Year maximum | 60% after deductible<br>15 visit Calendar Year maximum |
| **Mental Disorders/Substance Abuse** | Paid based on the type of service(s) received. | |
| **Preventive Care** | | |
| Routine Well Adult Care | 100% | 60% after deductible |
| Limited to: office visits, pap smear, prostate screening/PSA testing, one mammogram per year for females age 35 and older, and services required by law. | | |
| Routine Well Child Care | 100% | 60% after deductible |
| Including, but not limited to: office visits, routine physical examination, laboratory tests, x-rays, immunizations, and services required by law. | | |
| **Flu Shot** | 100% | Paid Same As Network |
| **Prescription Drugs** (30 day supply at retail only) | 80% after deductible | Paid Same As Network |
| **Organ Transplants** | Paid based on the type of service(s) received. | |
| **Other Medical Services and Supplies** | 80% after deductible | 60% after deductible |

**PRESCRIPTION DRUG BENEFIT SCHEDULE**
**PPO PLAN**

| **PRESCRIPTION DRUG BENEFIT** | | |
|---|---|---|
| | **NETWORK** | **NON-NETWORK** |
| **Retail and Mail Order (31-90 Day Supply)** | | |
| Generic & Brand Name Drugs | $20 copayment | Not Applicable |

**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.