Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
[840 First Street, NE]
[Washington, DC 20065]
[202-479-8000]

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT [C]
SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Evidence of Coverage.

CareFirst pays only for Covered Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, Copayment or Coinsurance. Services that are not listed in the Description of Covered Services, or are listed in the Exclusions and Limitations, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions and limitations in the Evidence of Coverage as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain Utilization Management requirements will also apply. When these requirements are not met, payments may be reduced or denied.

GENERAL PROVISIONS	
DEDUCTIBLES	
IN-NETWORK DEDUCTIBLE	**OUT-OF-NETWORK DEDUCTIBLE**
The Individual Deductible is $1,000 per Benefit Period. The Family Deductible is $2,000 per Benefit Period.	The Individual Deductible is $2,000 per Benefit Period. The Family Deductible is $4,000 per Benefit Period.

IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES

Individual Coverage: The Member must satisfy the Individual Medical Deductible.

Family Coverage: Each Member can satisfy his/her own Deductible by meeting the Individual Deductible. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Deductible. An individual family member may not contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible has been met, this will satisfy the Deductible for all covered family members.

The In-Network Deductible and the Out-of-Network Deductible do not contribute to one another.

The following amounts may <u>not</u> be used to satisfy the In-Network OR Out-of-Network Deductibles:

- Amounts incurred for failure to comply with Utilization Management Program requirements.
- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.
- Charges in excess of the Allowed Benefit.
- Charges for services not covered under the Evidence of Coverage or that exceed the maximum number of covered visits/days listed below.
- Charges for Pediatric Vision Services or Pediatric Dental Services.

[Deductible Credit

If a Member was covered on the day immediately preceding the effective date of this Evidence of Coverage under any other [compatible] group Evidence of Coverage [issued to the Group][,] then charges for Covered Services (as defined) Incurred by that Member and applicable toward Deductible expenses under the prior Evidence of Coverage, shall be used to satisfy all or any portion of the Deductible amounts under this Evidence of Coverage. This Deductible Credit provision applies only to the Deductible amount wholly or partially satisfied in the same [Benefit Period] [and] [tax year] as the effective date of this Evidence of Coverage. [Deductible credit only applies to initial enrollees.] [Deductible credit is not provided for Prescription Drugs.]]

OUT-OF-POCKET MAXIMUM

IN-NETWORK OUT-OF-POCKET MAXIMUM	OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM
The Individual Out-of-Pocket Maximum is $3,500 per Benefit Period. The Family Out-of-Pocket Maximum is $7,000 per Benefit Period. **The following amounts apply to the In-Network Out-of-Pocket Maximum:** • Copayments and Coinsurance for covered In-Network Services, including In-Network Pediatric Dental Services, Pediatric Vision and Prescription Drugs. • The In-Network Deductible. • The In-Network Pediatric Dental Deductible. When the Member has reached the In-Network Out-of-Pocket Maximum, no further Copayments, Coinsurance, or Medical Deductibles will be required in that Benefit Period for In-Network services.	The Individual Out-of-Pocket Maximum is $7,000 per Benefit Period. The Family Out-of-Pocket Maximum is $14,000 per Benefit Period. **The following amounts apply to the Out-of-Network Out-of-Pocket Maximum:** • Copayments and Coinsurance for covered Out-of-Network Services, including Out-of-Network Pediatric Dental Services and Prescription Drugs. • The Out-of-Network Deductible. • The Out-of-Network Pediatric Dental Deductible. When the Member has reached the Out-of-Network Out-of-Pocket Maximum, no further Copayments, Coinsurance, or Medical Deductibles will be required in that Benefit Period for Out-of-Network services.

IN-NETWORK AND OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM

Individual Coverage: The Member must meet the Individual Out-of-Pocket Maximum.

Family Coverage: Each Member can satisfy his/her own Out-of-Pocket Maximum by meeting the Individual Out-of-Pocket Maximum. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Out-of-Pocket Maximum. An individual family member may not contribute more than the Individual Out-of-Pocket Maximum toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met, this will satisfy the Out-of-Pocket Maximum for all covered family members.

The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum do not contribute to one another.

The following amounts may <u>not</u> be used to meet the In-Network or Out-of-Network Out-of-Pocket Maximum:

- Amounts incurred for failure to comply with Utilization Management Program requirements.
- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.
- Charges in excess of the Allowed Benefit.
- Charges for services not covered under the Evidence of Coverage or that exceed the maximum number of covered visits/days listed below.

- Charges for Out-of-Network Pediatric Vision Services.

UTILIZATION MANAGEMENT

Failure or refusal to comply with Utilization Management Program requirements will result in a 50% reduction in benefits for services associated to the Member's care or treatment. This reduction will not apply to Prescription Drugs, and Pediatric Vision and Pediatric Dental benefits.

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES				
Freestanding Physician's Office		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Hospital-Based Outpatient Department/Clinic/ Office (non-surgical)	The In-Network Deductible, Copayment and Coinsurance do not apply to covered preventive services.	In-Network and Out-of-Network	$50 per visit	20% of the Allowed Benefit
Laboratory Tests	The In-Network Deductible, Copayment and Coinsurance do not apply to covered preventive services.	In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Radiologic Imaging	The In-Network Deductible, Copayment and Coinsurance do not apply to covered preventive services.	In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Other Diagnostic Testing (except as otherwise provided)	The In-Network Deductible, Copayment and Coinsurance do not apply to covered preventive services.	In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Preventive Care - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA).				
Prostate Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Colorectal Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Pap Smear		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Human Papillomavirus Screening Test		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Immunizations		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Well Child Care (includes related lab tests and immunizations)		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Adult Preventive Care (includes related services)		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Gynecological Care (includes related services)		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Services for Obesity		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Treatment Services				
Professional Nutritional Counseling and Medical Nutrition Therapy	Benefits available when provided in conjunction with preventive services, diabetic education, and hospice care.	In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Office Visits for Treatment of Childhood Obesity	Limited to Members under age 19.	No	No Copayment or Coinsurance	No Copayment or Coinsurance
Family Planning				

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Non-Preventive Gynecological Care		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Contraceptive Counseling		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Contraceptive Drugs and Devices		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs	Drug or device must be approved by the FDA as a contraceptive.	Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Elective Sterilization Services – Female Members	Benefits available to female Members with reproductive capacity, only.	Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Maternity and Related Services				
Preventive Services		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Non-Preventive Services		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Professional Services for Delivery		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Professional Services for Nursery Care		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Allergy Services				

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Allergy Testing and/or Allergy Treatment		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Allergy Shots		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Outpatient Rehabilitative Services				
Rehabilitative/ Habilitative Physical Therapy		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Rehabilitative/ Habilitative Occupational Therapy		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Rehabilitative/ Habilitative Speech Therapy		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Spinal Manipulation Services		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Habilitative Services for Children	Limited to Members under the age of twenty-one (21)	In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Habilitative Services for Adults	Benefits available for Members age twenty-one (21) and older Limited to thirty (30) visits (per injury or illness) per Benefit Period for Physical Therapy, thirty (30) visits (per injury or illness) per Benefit Period for Occupational Therapy and thirty (30) visits (per injury or illness) per Benefit Period for Speech Therapy. Prior authorization required	In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Cardiac Rehabilitation	Limited to ninety (90) days per Benefit Period	In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Pulmonary Rehabilitation	Limited to one (1) pulmonary rehabilitation program per lifetime	In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Other Treatment Services				
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation and pulmonary rehabilitation)		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Blood and Blood Products		In-Network and Out-of-Network	$50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit
Clinical Trial		Benefits are available to the same extent as benefits provided for other services.		
Organ and Tissue Transplants	Except for cornea transplants and kidney transplants, prior authorization is required.	Benefits are available to the same extent as benefits provided for other services.		
Outpatient Surgical Facility and Professional Services				
Surgical Care at an Outpatient Hospital Facility		In-Network and Out-of-Network	$250 per visit	20% of the Allowed Benefit
Surgical Care at an Ambulatory Care Facility		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Surgical Professional Services Provided at an Outpatient Hospital or Ambulatory Care Facility	Preventive Colonoscopy is not subject to In-Network Deductible, Copayment or Coinsurance.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL SERVICES				
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	Prior authorization is required except for emergency admissions and all maternity admissions. Hospitalization solely for rehabilitation limited to ninety (90) days per Benefit Period.	In-Network and Out-of-Network	$500 per admission	20% of the Allowed Benefit
Inpatient Physician and Surgical Services (except for delivery services and nursery services under Maternity and Related Services)		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit per provider per date of service
SKILLED NURSING FACILITY SERVICES				
Skilled Nursing Facility Services	Limited to sixty (60) days per Benefit Period. Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
HOME HEALTH CARE SERVICES				
Home Health Services	Limited to ninety (90) visits per "episode of care". A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for sixty (60) consecutive days. Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Postpartum Home Visits	Benefits are available to all Members.	No	No Copayment or Coinsurance	No Copayment or Coinsurance

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
HOSPICE SERVICES				
Inpatient Care	Prior authorization is required. Services limited to a maximum one hundred eighty (180) day hospice eligibility period. Limited to sixty (60) days per hospice eligibility period.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Care	Prior authorization is required. Services limited to a maximum one hundred eighty (180) day hospice eligibility period.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Respite Care	Services limited to a maximum one hundred eighty (180) day hospice eligibility period.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Bereavement Services	Covered only if provided within ninety (90) days following death of the deceased.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES				
Outpatient Services				
Office Visits		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Hospital Facility Services		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Professional Services Provided at an Outpatient Hospital Facility		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit per provider per date of service
Medication Management		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Methadone Maintenance		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Partial Hospitalization		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Professional Services at a Partial Hospitalization Facility		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit per provider per date of service

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Inpatient Services				
Inpatient Facility Services	Prior authorization is required.	In-Network and Out-of-Network	$500 per admission	20% of the Allowed Benefit
Inpatient Professional Services		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit per provider per date of service
EMERGENCY SERVICES AND URGENT CARE				
Limited Service Immediate Care		In-Network and Out-of-Network	$30 per visit	20% of the Allowed Benefit
Urgent Care Facility		In-Network and Out-of-Network	$30 per visit	Paid as In-Network
Hospital Emergency Room	Limited to Emergency Services or unexpected, urgently required services.	In-Network and Out-of-Network	$250 per visit, waived if admitted	Paid as In-Network
Hospital Emergency Room Professional Services	Limited to Emergency Services or unexpected, urgently required services.	No	No Copayment or Coinsurance	Paid as In-Network
Emergency Transportation/ Ambulance	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency.	In-Network and Out-of-Network	No Copayment or Coinsurance	Paid as In-Network
MEDICAL DEVICES AND SUPPLIES				
Durable Medical Equipment		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Breastfeeding Equipment and Supplies		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Diabetes Equipment and Supplies		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Hair Prosthesis	Limited to one (1) hair prosthesis per Benefit Period.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT				

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Associated Costs for the Patient-Centered Medical Home Program (PCMH)		In-Network	No Copayment or Coinsurance	Not covered
Enhanced Monitoring Program	Limited to services rendered by Designated Providers.	In-Network	No Copayment or Coinsurance	Not covered
Chronic Care Coordination Program		In-Network	No Copayment or Coinsurance	Not covered
Complex Case Management (CCM)		In-Network	No Copayment or Coinsurance	Not covered
Comprehensive Medication Review (CMR)	Limited to services rendered by Designated Providers.	In-Network	No Copayment or Coinsurance	Not covered
Expert Consultation Program (ECP)	Limited to services rendered by Designated Providers.	In-Network	No Copayment or Coinsurance	Not covered
Home Based Services Program (HBS)		In-Network	No Copayment or Coinsurance	Not covered
PRESCRIPTION DRUGS				

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs	If a Generic Drug is not available, a Non-Preferred Brand Name Drug shall be dispensed. Limited to a 34-day supply of Prescription Drugs. Diabetic supplies and oral chemotherapy drugs are not subject to the Copayment or Coinsurance. The Member shall pay the lesser of the cost of the prescription or the applicable Copayment.	In-Network and Out-of-Network benefit subject to In-Network Deductible	**Preferred Preventive Drugs:** No Copayment or Coinsurance **Generic Drugs:** $10 per prescription **Preferred Brand Name Drugs:** $45 per prescription **Non-Preferred Brand Name Drugs:** $65 per prescription **Specialty Drugs:** 50% of the Prescription Drug Allowed Benefit per prescription	
Maintenance Drugs	If a Generic Drug is not available, a Non-Preferred Brand Name Drug shall be dispensed. Limited to a 90-day supply of Maintenance Drugs. Diabetic supplies and oral chemotherapy drugs are not subject to the Copayment or Coinsurance. The Member shall pay the lesser of the cost of the prescription or the applicable Copayment.	In-Network and Out-of-Network benefit subject to In-Network Deductible	**Preferred Preventive Drugs:** No Copayment or Coinsurance **Generic Drugs:** **$**20 per prescription **Preferred Brand Name Drugs:** $90 per prescription **Non-Preferred Brand Name Drugs:** $130 per prescription **Specialty Drugs:** 50% of the Prescription Drug Allowed Benefit per prescription	

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year.				
			MEMBER PAYS	
SERVICE	**LIMITATIONS (Combined In-Network and Out-of-Network)**	**SUBJECT TO DEDUCTIBLE?**	**CONTRACTING VISION PROVIDER**	**NON-CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $40
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.				
Basic Single vision	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $40
Basic Bifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $60
Basic Trifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $80
Basic Lenticular	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $100
Frames				
Frames	Limited to one frame per Benefit Period. Covered Vision Services rendered by Contracting Vision Providers limited to frames contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit are of $70
Low Vision				
Low Vision Eye Examination	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $300

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year.				
			MEMBER PAYS	
SERVICE	**LIMITATIONS (Combined In-Network and Out-of-Network)**	**SUBJECT TO DEDUCTIBLE?**	**CONTRACTING VISION PROVIDER**	**NON-CONTRACTING VISION PROVIDER**
Follow-up care	Prior authorization required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to four visits in any five-year period.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $100
High-power Spectacles, Magnifiers and Telescopes	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $600
Contact Lenses				
Elective	Includes evaluation, fitting and follow-up fees. Limited to one per Benefit Period. Covered Vision Services rendered by Contracting Vision Providers limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $105
Medically Necessary	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to one per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Pediatric Vision Allowed Benefit of $225

Pediatric Dental – Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services through the rest of that Calendar Year.	
Pediatric Dental Deductible	
The In-Network Deductible of $25 per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services. The In-Network Pediatric Dental Deductible and the Out-of-Network Pediatric Dental Deductible are separate amounts and do not contribute to one another.	The Out-of-Network Deductible of $50 per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services. The Out-of-Network Pediatric Dental Deductible and the In-Network Pediatric Dental Deductible are separate amounts and do not contribute to one another.
Pediatric Dental Out-of-Pocket Maximum	
Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the Out-of-Pocket Maximum stated above. Once the Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.	

SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS	
			IN-NETWORK	OUT-OF-NETWORK
Class I Preventive & Diagnostic Services		No	No Coinsurance	20% of the Pediatric Dental Allowed Benefit
Class II Basic Services		Yes	20% of the Pediatric Dental Allowed Benefit	40% of the Pediatric Dental Allowed Benefit
Class III Major Services – Surgical		Yes	20% of the Pediatric Dental Allowed Benefit	40% of the Pediatric Dental Allowed Benefit
Class IV Major Services – Restorative		Yes	50% of the Pediatric Dental Allowed Benefit	65% of the Pediatric Dental Allowed Benefit
Class V Orthodontic Services	Limited to Medically Necessary Orthodontia	No	50% of the Pediatric Dental Allowed Benefit	65% of the Pediatric Dental Allowed Benefit

Group Hospitalization and Medical Services, Inc.
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