

**SCHEDULE OF BENEFITS**  
**Mid Plan**

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in your Summary Plan Description. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

<b>Your Responsibilities</b>	<b>In network</b>	<b>Out of network</b>
<b>Deductible</b>	\$1,000 individual \$2,000 family	\$2,000 individual \$4,000 family
<b>Coinsurance</b>	20%	40%
<b>Annual Medical out of pocket</b> (Deductible, coinsurance and medical copays)  In-network amounts accumulate to the out-of-network out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	\$2,000 individual \$5,000 family	\$5,000 individual \$10,000 per family
<b>Annual Prescription out of pocket</b>	\$4,850 individual \$8,450 family	
<b>Common Accident Deductible:</b> If two or more members of the same family are injured in a common accident, only one deductible amount, if applicable, will be applied.		
<b>Deductible Carryover:</b> If a covered person incurs eligible charges during the period beginning October 1 through December 31 which are applied to the deductible for that calendar year, these charges are also applied toward satisfaction of the deductible for the subsequent calendar year.		

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Ambulance services</b>	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
<b>Anesthesia services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Chiropractic Services</b>		
• <b>Office Visit</b>	\$45 copay then subject to deductible and coinsurance	\$45 copay then subject to deductible and coinsurance
• <b>Therapies, manipulations, and X-rays</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Durable medical equipment and medical supplies</b> (Including insulin pump and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hearing examinations (diagnostic)</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Home health care</b> <ul style="list-style-type: none"> <li>Limited to 40 visits per calendar year.</li> <li>Additional 40 visits available if terminally ill (hospice).</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospice care</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital emergency room services</b>		
<ul style="list-style-type: none"> <li><b>Emergency room facility</b> (Copayment waived if admitted to hospital as inpatient)</li> </ul>	\$150 copayment per visit then subject to coinsurance.	\$150 copayment per visit then subject to in network coinsurance.
<ul style="list-style-type: none"> <li><b>Other emergency room services</b></li> </ul>	Subject to deductible and coinsurance	Subject to in network deductible and coinsurance
<b>Hospital inpatient services</b> <ul style="list-style-type: none"> <li><b>Precertification required</b> (Including semi-private or special care room, operating room, ancillary services and supplies)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital outpatient and surgical center services</b> (Not including emergency room)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Maternity services</b>		
<ul style="list-style-type: none"> <li><b>Hospital services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Physician services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Mental health and substance abuse services</b>		
<ul style="list-style-type: none"> <li><b>Inpatient care</b> (Pre-certification required)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Outpatient Office Visit</b></li> </ul>	\$45 copay then subject to coinsurance	\$45 copay then subject to coinsurance
<ul style="list-style-type: none"> <li><b>Testing and evaluation</b></li> </ul>	100% of first \$500, then subject to coinsurance	100% of first \$500, then subject to coinsurance
<ul style="list-style-type: none"> <li><b>Transitional care</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
<b>Office visit</b>	\$30 copay for primary care provider, \$45 copay for specialist. Balance subject to coinsurance.	\$30 copay for primary care provider, \$45 copay for specialist. Balance subject to coinsurance.
<b>Outpatient laboratory Services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient radiology Services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient therapy services</b>		
<ul style="list-style-type: none"> <li>• <b>Medical Biofeedback</b> (As part of an approved pain management program only)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Occupational therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Physical therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Speech therapy</b> (Refer to the SPD for specific limitations)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Physician services</b>		
<ul style="list-style-type: none"> <li>• <b>Hospital services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Other services in an office</b></li> </ul>	Subject to deductible and coinsurance  (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance
<b>Preventive benefit</b> Please refer to Security Administrative Services' Preventive Service Guidelines at <a href="http://www.securityhealth.org">www.securityhealth.org</a> under Health Care Reform for service frequency recommendations.		
<ul style="list-style-type: none"> <li>• <b>Comprehensive physical examination</b> (complete physical)                ~ Well-baby care                ~ Well-child care                ~ Adolescent well-care                ~ Adult well-care</li> </ul>	Covered at 100%	Covered at 100%
<ul style="list-style-type: none"> <li>• <b>Gynecological examination for women</b> (breast exam and pelvic exam)</li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance

Your Benefits	In network	Out of network
<ul style="list-style-type: none"> <li><b>Digital prostate examination for men</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Mammogram to screen for breast cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Pap smear to screen for cervical cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Colonoscopy screening for colorectal cancer</b></li> </ul>	1 every two years then subject to deductible and coinsurance	1 every two years then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Other screenings for colorectal cancer</b>            ~ Sigmoidoscopy            ~ Double contrast barium enema            ~ Fecal occult blood testing</li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Screening laboratory services</b>            Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.</li> </ul>	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Bone mineral density (dexa scan) to screen for osteoporosis in women</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Chlamydia screening for women</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Ultrasound for screen of an abdominal aortic aneurysm for men</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	1 per calendar year then subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Immunizations and vaccinations (including those needed for travel)</b></li> </ul>	Covered at 100%	Covered at 100%
<b>Skilled nursing facility</b> <ul style="list-style-type: none"> <li><b>Limited to 107 days per calendar year</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Surgical services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Transplant services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Vision examinations (diagnostic)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
All other covered	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Wellness Benefit</b> The following routine services are covered up to the \$600 maximum per participant and no further benefits are available for the remainder of the calendar year:		
<ul style="list-style-type: none"> <li>• <b>Health Fitness Organizations</b> (Must attend 8 sessions per month)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine Dental Care</b> (Limited to 2 exams and 1 X-ray. Teeth cleaning with fluoride. Sealants for children under 15.)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Smoking Cessation</b> (Must attend 80% of sessions per month.)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Sports Physical</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine vision exam and refraction including frames and lenses</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Routine hearing care including hearing checks</b></li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit
<ul style="list-style-type: none"> <li>• <b>Weight Loss Programs</b> (Must attend 80% of sessions per month.)</li> </ul>	Covered at 100% of PPO rate, to limit	Covered at 100% of PPO rate, to limit

Pharmacy	
<p><b>Prescriptions that are available in generic must be received in generic or the insured will pay the difference in the cost between the generic and name brand. The difference will not apply towards the prescription out of pocket.</b></p> <p><b>Limited to a 90 day supply for both retail and mail order.</b></p>	<p>5% of total cost per tier 1 prescription or refill.            20% of total cost per tier 2 prescription or refill.            25% of total cost per tier 3 prescription or refill.            30% of total cost per tier 4 prescription or refill to annual maximum of \$2500.</p> <p>Prescriptions will have an out of pocket of maximum of \$4,850/individual or \$8,450/family.</p>