

SCHEDULE OF BENEFITS

Plan Sponsor: Douglas County
Benefit Period: June 1 to May 31

Primary Plan Covered Services	In-Network	Out-of-Network
Lifetime Benefit Maximum	\$1,000,000	
Deductible (per Benefit Period)		
Individual	\$0	\$400
Family	\$0	\$800
<i>Other special deductibles may apply to specific services</i>		
Out-of-Pocket Maximum <i>(includes Deductible)</i>		
Individual	\$1,300	\$3,000
Family	\$2,600	\$6,000
Standard Benefit Percentage	80%	60%
Benefit Percentage for In-Network care by an Out-of-Network Provider:	In-Network Rate	
Benefit Percentage for Out-of-Network Care While Traveling Outside the Network Area:	Out-of-Network rate, Deductible waived	

NOTE: Because of special discount arrangements for individuals covered under this Plan, services rendered by the following “Contracted Providers” will be payable at the Network rate:

- ★ Douglas County Visiting Nurse Association
- ★ Bert Nash Community Mental Health Center, Inc.
- ★ Lawrence/Douglas County Ambulance Service
- ★ Qualicare

Primary Plan Covered Services	In-Network	Out-of-Network
	Deductible and Co-insurance Apply Except as Provided:	
Physician Services Office Visits	100% after \$15 Co-pay	60%
Lab/X-Ray	80%	60%
<i>Services rendered at time of visit</i>		
Preventive Care Mammogram/pap smear PSA Tests Immunizations Routine Physical Examinations for Employee, Spouse and each covered Dependent Child (age 2 and over) Vision Exam (<i>1 exam per year</i>) \$50 Max. for purchase of eyewear	100%	100% (Deductible waived)
	<i>\$400 Aggregate Preventive Care Maximum per Benefit Period</i>	
Well Child/Well Baby Care (under age 2 includes immunizations and office visit)	100% after \$15 Co-pay	100% after \$15 Co-pay (Deductible waived)
Preventive Colonoscopy (age 50 and over) Initial Colonoscopy	100%	100% (Deductible applies)
Subsequent Preventive Colonoscopies (limited to one (1) every five years)	80%	60%
Hospital Care	80%	60%
Outpatient Surgery	80%	60%
Emergency Room¹ <i>Co-pay waived if admitted</i>	\$50 Co-pay, then 80%	\$100 Co-pay, then 60% after the Deductible
Private Duty Nursing \$2,000 Max. per Benefit Period	80%	60%
Ambulance	80%	60%
Organ Transplant \$500,000 Max. per transplant	80%	60%
Skilled Nursing Facility 60 Days Max. per Benefit Period	50%	50%
Home Health Care 120 visits per disability Max. per Benefit Period	80%	60%
Hospice Care	80%	60%

¹ Coverage for emergency room treatment at an Out-of-Network Hospital for conditions that meet the definition of *Emergency*, payment will be considered at the In-Network level for Covered Expenses received in the emergency room. If you are then admitted to the Out-of-Network Hospital, Covered Expenses for Hospital and Physician services will be considered at the In-Network level until your Attending Physician determines it is medically appropriate for you to be transferred.

Primary Plan Covered Services	In-Network	Out-of-Network
Rehabilitation Facility	80%	60%
Physical, Occupational, and Speech Therapy <i>90 visits combined Max. per Benefit Period</i>	80%	60%
Chiropractic Care <i>\$25 Max. per visit</i> <i>\$500 Max. Benefit per Benefit Period</i>	50%	50% (Deductible waived)
Mental and Nervous/Substance Abuse		
Inpatient	80%	60%
Outpatient	80%	60%
Preadmission Testing (with in 7 days of admission)	100%	100% (Deductible waived)
Second Surgical Opinion	100%	100% (Deductible waived)
Durable Medical Equipment	80%	60%
Allergy Shots and Testing	80%	60%
TMJ Treatment <i>\$2,500 Lifetime Benefit Maximum</i>	80%	80% (Deductible waived)
Impacted Teeth	80%	80% (Deductible waived)

<i>PRESCRIPTION DRUG BENEFITS</i>	
Retail Pharmacy (30-day supply): Generic (preferred) Brand Name (preferred) <i>One Co-payment applies per 30 days of medication</i>	\$8 Co-pay \$35 Co-pay
Retail 90-Day Generic (preferred) Brand Name (preferred)	\$24 Co-pay \$105 Co-pay
Compound Drugs	\$40 Co-pay or 50% of the cost of the compound, whichever is higher
<p>If a generic equivalent of a prescription Drug is available and the Covered Person chooses the brand name over the generic equivalent, then he or she must pay the cost difference between the generic and brand name Drug in addition to the brand name Co-pay. However, if there is a documented medical reason (such as an allergic reaction) for the brand name Drug to be dispensed, this provision is waived and the Covered Person will pay only the brand name Co-pay.</p>	
<p>Prescriptions filled Out-of-Network, if purchased after hours due to an Emergency or while the Covered Person is on vacation, must be submitted manually to Administrative Services who will send them to the Pharmacy Benefit Manager for reimbursement. The Covered Person will be reimbursed the amount paid, less the Co-pay due, plus a manual claim fee.</p>	

<i>DENTAL BENEFITS</i>	
Maximum Benefit Class I, II and III Combined (per person per Benefit Period)	\$1,250 per Benefit Period per Covered Person
Deductible (per Benefit Period) Individual	\$50 per Covered Person Deductible Waived for Class I (Preventive Services); Maximum of two (2) per family
Benefit Percentages: Class I Class II Class III	100% 80% 50%