St. John's Health System

Effective Date of Coverage 01/01/2007

2007 Benefit Schedule

SERVICES	CO-PAYMENT and LIMITATIONS (if applicable)
MEDICAL SERVICES Services and Supplies	$ 25 Co-payment per office visit for Primary care $ 45 Co-payment per office visit for Specialist care $ 45 Co-payment Well Woman Exam including Pap Smear (In- Network only)
Surgical services and other medical care (Including anesthesia and hospital visits.)	$ 0 Co-payment
Surgery or assessments performed in a Physician's Office	$ 35 Co-payment (Procedure Co-pay)
Immunizations	$ 0 Co-payment Routine immunizations as recommended (AAP, AAFP, and CDC) for residents of the United States. This excludes immunizations required for international travel.
Office Consultations Non-Participating- (If approved in Advance by St. John's Health Plans)	$ 25 Co-payment per office visit for Primary care $ 45 Co-payment per office visit for Specialist care
Allergy Services - Office Visits - Injections/Treatment	$25 Co-payment per office visit for Primary care $45 Co-payment per office visit for Specialist care $5 Co-payment 20% Co-payment for serum
Lab, X-Ray and Other Diagnostic Services	$ 0 Co-payment $150 PET Co-payment $150 CT Co-payment $150 MRI Co-payment
Maternity - Office Visits - Lab, X-Ray and Other Diagnostic Services	One time $45 Co-payment for all office visits associated with prenatal care during a single pregnancy. $0 Co-payment. Sonograms in uncomplicated pregnancies are limited to two per pregnancy

SERVICES	CO-PAYMENT and LIMITATIONS (if applicable)
INPATIENT HOSPITAL SERVICES	$ 150 Co-payment per day for every day hospitalized, provided that the total Co-payment maximum does not exceed $600 per admission.
OUTPATIENT SERVICES Emergency Care - Service and Supplies	$ 150 Co-payment per visit, except Co-payment charge will be waived when inpatient admission for the same condition occurs within 24 hours The Participating Primary Care Physician must be notified no later than 48-hours after service or as soon as medically possible to receive authorization for continued services.
Non-Emergency Services - Outpatient Surgery	$ 150 Co-payment per outpatient surgery
Urgent Care Center	$ 60 Co-payment per visit
Outpatient Rehabilitative Therapy Services (includes physical, speech, and occupational therapy)	$ 25 Co-payment per visit Coverage maximum for up to sixty (60) visits per calendar year for an acute Injury or Illness for which therapy is reasonably expected to result in a material improvement in the physical condition of the employee. Services are covered when ordered by or monitored by a Participating Physician at a Participating Provider and may require preauthorization. The sixty-visit limit includes all visits for all therapy types combined, whether services are provided in the outpatient hospital setting, or a free standing center. The sixty-visit is not renewable. Home rehabilitation services are limited to the home bound patient and considered separately under the Home Health Benefit. Cognitive therapy is a covered benefit for acute brain injury when part of a plan approved inpatient or outpatient rehabilitation program and is also included in the therapy benefit limit of sixty visits for all therapies. Rehabilitation Therapy Services that are considered maintenance, developmental, or educational in nature are not covered benefits. Coverage maximum for cardiac and pulmonary rehabilitation of one cycle up to 36 visits within a 12 week period per year are considered Medically Necessary and may require preauthorization. The rehabilitative therapy services co-pay applies.

Observation	$ 150 Co-payment per day for every day hospitalized, provided that the total Co-payment maximum does not exceed $600 per admission.
Nutritional Counseling	$ 25 Co-payment per visit
MENTAL HEALTH/ALCOHOLISM/ CHEMICAL DEPENDENCY SERVICES Outpatient Therapeutic Services for Mental Illness	$ 15 Co-payment per group session/visit $ 25 Co-payment per individual session/visit Outpatient Mental health, diagnostic crisis intervention, and therapeutic services. Coverage includes two (2) visits each Calendar year to diagnose or assess a Mental Illness, in or out of network, without prior authorization.
Inpatient Services for Mental Illness	$ 150 Co-payment per day for every day hospitalized, provided the total Co-payment maximum does not exceed $600 per admission. Coverage to a maximum of ninety (90) days for Mental Health treatment per employee per Calendar year, when authorized in advance by the Plan. Coverage includes treatment in an accredited residential center.
Outpatient Therapeutic Alcoholism and Chemical Dependency Services	$ 15 Co-payment per group session $ 25 Co-payment per individual session/visit Coverage for up to a maximum of twenty (20) days total outpatient treatment for each Calendar year. The total days allowed for inpatient treatment can be converted for use for outpatient treatment on a two-for-one basis (i.e., one (1) inpatient day converts into two (2) outpatient visits). A lifetime limit of eighty (80) days for outpatient treatment applies to this service.
Inpatient Alcoholism and Chemical Dependency Services	$ 150 Co-payment per day for every day hospitalized, provided that the total Co-payment maximum does not exceed $600 per admission. Coverage for up to a maximum of thirty (30) days total inpatient treatment for each Calendar year. The total days allowed for inpatient treatment can be converted for use for outpatient treatment on a two-for-one basis (i.e., one (1) inpatient day for two (2) outpatient days. A lifetime limit of one hundred twenty (120) days for inpatient treatment applies to this service.
MISCELLANEOUS COVERED SERVICES Home Health Agency Services	20% Co-insurance Coverage for up to a maximum of sixty (60) visits per calendar year.
Skilled Nursing Facility Services	20% Co-insurance Coverage for up to a maximum of one hundred twenty (120) days per calendar year.

Hospice Services	$ 0 Co-insurance Hospice services are not covered if received out-of-network.
Ambulance	$ 0 Co-payment
Prosthetic Devices	20% Co-insurance The total benefit allowable for medically necessary Prosthetic Devices is limited to $10,000 per calendar year. Please note the limitation does not apply to breast prostheses.
Orthotic Devices	20% Co-insurance
Durable Medical Equipment and Supplies	20% Co-insurance The total benefit allowable for medically necessary DME is limited to $5,000 per calendar year. In no event shall orthodontic braces, humidifiers, air conditioners, dehumidifiers or similar personal comfort items be treated as Durable Medical Equipment for purposes of this Plan. Durable Medical Equipment in excess of $500.00 must be approved in advance by the Chief Medical Officer. Durable Medical Equipment is not modified, repaired, or replaced unless necessitated by the Member's medical condition. The Plan may replace an item because of severe damage or loss through no intentional act of the Member or a third party, however, an item is not replaced more frequently than once per calendar year. Durable Medical Equipment may be purchased or rented based on approved acceptable medical practices of the Plan.
Surgical Implants	$0 Co-payment
Diabetes Services	Co-payment consistent with type of service required
Transplant Services	$ 0 Co-payment
Dialysis	$ 0 Co-payment
Mammography	$ 0 Co-payment Low-dose mammography screening for non-symptomatic Members which shall include the following: a. A baseline mammogram for female Members ages thirty-five (35) to thirty-nine (39), inclusive; b. A mammogram every year for female Member's age forty (40) and over; and

	c. A mammogram for any female, upon the recommendation of her Primary Care Physician, or a Participating Specialist Physician where such female, her mother, or sister has prior history of breast cancer.
Routine Eye Care Services	NO COVERAGE AVAILABLE.
Nutritional Supplements	0% Co-payment for a thirty (30) day supply
Accidental Dental	20% Co-insurance
Injectables	20% Co-insurance with a maximum of $100 per 30 day supply.

SCHEDULE B – IN NETWORK MAXIMUM CO-PAYMENTS	
Subscriber Only	$ 1,100 Co-payments
Subscriber and one Dependent	$ 2,200 Co-payments
Subscriber and two or more Dependents	$ 3,300 Co-payments

Employee Assistance	Short-term counseling for a maximum of four (4) counseling sessions in a calendar year. $ 0 Co-payment for Participating Health Provider
Chiropractic Services	$45 Specialist Office visit $500 annual maximum benefit (Must be a Participating Health Provider)
Outpatient Prescription Drug	• ***<u>Initial</u>*** **Prescriptions at an SJHS Pharmacy & all other Caremark, non-SJHS Pharmacies:** $15 Co-payment for Generic Drugs $30 Co-payment for Preferred Brand Drugs • ***<u>Refills</u>*** **at an SJHS Pharmacy: *<u>(Allows for a 90 day supply, Co-pay amount x 3)</u>*** $15 Co-payment for Generics $30 Co-Payment for Preferred Brands • ***<u>Refills</u>*** **at all other Caremark, non-SJHS Pharmacies*<u>(Only allows for a 30 day supply)</u>*** $25 Co-Payment for Generics $45 Co-Payment for Preferred Brands ***! Due to transportation regulations of prescriptions all Arkansas based co-workers will always pay the initial prescription cost (Allowing for a 90-day supply Co-pay amount x 3)!*** ***<u>(ALL CO-PAYS PER 30 DAY SUPPLY)</u>*** • No Annual Drug Deductible • 20% Co-payment with a maximum of $100 per 30 day supply or refill for certain Specialty Pharmaceuticals • 50% Co-payment for certain Non-Preferred Brand-name Drugs (as specified by the Plan) If a brand drug is dispensed when a Generic equivalent that is subject to a Maximum Allowable

	Cost is available, the Member pays the Generic Co-payment plus a Service Charge. A Service Charge is equal to the difference between the cost of the Brand-name drug and the cost of the Generic substitute, reflected by the Maximum Allowable cost. The Member pays a Service Charge whether they choose to receive the Brand-name drug or the prescribing Physician requests that the Brand-name drug be dispensed when a Generic equivalent is available.
Out-of-Network Rider	$ 500 Deductible Per Member Per Calendar Year $ 1000 Deductible Per Family Per Calendar Year $Unlimited Out-of-Pocket Maximum Per Member (Excluding Deductible) $Unlimited Out-of-Pocket Maximum Per Family (Excluding Deductible) 60% of Eligible Charges after satisfaction of deductible 50% of Eligible Charges after satisfaction of deductible for injections, serums or treatments for allergy services when no charge is made for physician services.
Wellness, Disease Management and Preventative Programs	• Co-pays as applicable
St. John's Dental Services Rider	Co-payment consistent with type of service required
Oral Surgery Rider	NO COVERAGE AVAILABLE.