

Physicians' Benefits Trust Life Insurance Company

Resurrection Health Care Physicians' Benefits Plan PPO C

This option is designed as a three-tiered benefit plan. Benefits will be payable at the highest tier only for treatment and services received at Resurrection Hospital (RHC) facilities. Any other treatment and services will be considered payable at the in-network and out-of-network levels.

**This is only a brief description of benefits. Your Plan's Certificate of Insurance and its state provisions will provide additional information and will always supersede the information provided by this document.*

SCHEDULE OF COVERED EXPENSES

BENEFITS and PROVISIONS	RHC Facilities	In-Network	Out-of-Network
Calendar Year Deductible <i>(must be satisfied before benefits are payable unless waived).</i>	\$2,500, \$5,000, \$10,000 per person \$5,000, \$10,000, \$20,000 per family (2x the individual)		
Out-of-Pocket Maximum per Calendar Year <i>(excludes Deductible). After amount is reached, 100% level of benefits applies for that Calendar Year.</i> <i>Note: In-Network and Out-of-Network Out-of-Pocket amounts are separately tracked.</i>	Deductible Amount	\$1,000 per person \$2,000 per family (Plus Deductible)	
Annual Maximum Amount Payable		\$5,000,000 per person	
For Organ and Transplant procedures when pre-certification procedures are not followed, a penalty will apply			
Prescription Drug Card Benefit <i>(up to 34-day supply through participating pharmacies)</i>	\$15 co-pay/Generic, \$30 co-pay/Preferred Brand, \$45 co-pay/Non-Preferred Brand per prescription, remainder at 100%. <u>No Deductible</u>		
Mail Order Drug Benefit <i>(up to 90-day supply per prescription).</i>	\$30 co-pay/Generic, \$60 co-pay/Preferred Brand, \$90 co-pay/Non-Preferred Brand per prescription, remainder at 100%. <u>No Deductible</u>		
BENEFITS and PROVISIONS	RHC Facilities	In-Network	Out-of-Network

SCHEDULE OF COVERED EXPENSES

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<p>Preventive Care includes routine exams, including routine physicals, associated lab tests, pap smears and immunizations, outpatient female contraceptive management, well baby care to age 19, smoking cessation)</p> <ul style="list-style-type: none"> • Routine physical and gynecological exam limited to one exam per Calendar Year. • Routine Mammogram limited to one per Calendar Year.* • Routine Prostate Exam (PSA) limited to one per Calendar Year.* • Colorectal Cancer screening, exams and tests as prescribed by a physician in accordance with the published American Cancer Guidelines or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or Federal Government Agencies, including the National Cancer Institute, the Center for Disease Control and Prevention, and the American College of Gastroenterology. <p>*Additional benefits payable as any other illness, subject to deductible and co-insurance.</p>	<p><u>Facility Charges</u></p> <p>100%</p> <p><u>Deductible Waived</u></p>	<p><u>Facility Charges and Non-Facility Charges</u></p> <p>100%</p> <p><u>Deductible Waived</u></p>	<p><u>Facility Charges</u></p> <p>50%</p> <p><u>Non-Facility Charges</u></p> <p>90%</p> <p><u>Deductible Waived</u></p>
<p>Newborn Routine Nursery Care. (See Other Covered Services for Maternity benefits)</p> <ul style="list-style-type: none"> • Includes Circumcision <p>To a Maximum of 4 days.</p>	<p><u>Facility Charges Only</u></p> <p>100%</p> <p><u>Deductible Waived</u></p>	<p><u>Facility Charges</u></p> <p>90%</p> <p><u>Non-Facility Charges</u></p> <p>100%</p> <p><u>Deductible Waived</u></p>	<p><u>Facility Charges</u></p> <p>50%</p> <p><u>Non-Facility Charges</u></p> <p>90%</p> <p><u>Deductible Waived</u></p>
<p>Medically Necessary Services in Physician's Office (Office Visit Only)</p>	<p>N/A</p>	<p><u>Non-Facility Charges</u></p> <p>100%</p>	<p><u>Non-Facility Charges</u></p> <p>90%</p>
<p>Other Physician Services</p>	<p>N/A</p>	<p><u>Non-Facility Charges</u></p> <p>100%</p>	<p><u>Non-Facility Charges</u></p> <p>90%</p>
<p>Chiropractic Care</p> <p>After satisfaction of deductible not to exceed \$50 per visit.</p>	<p>N/A</p>	<p>100%</p>	
<p>Outpatient Occupational Therapy</p> <p>Limited to \$3,000 per incident or occurrence. However, additional benefits payable if medically necessary.</p>	<p><u>Facility Charges Only</u></p> <p>100%</p>	<p><u>Facility Charges</u></p> <p>90%</p> <p><u>Non-Facility Charges</u></p> <p>100%</p>	<p><u>Facility Charges</u></p> <p>50%</p> <p><u>Non-Facility Charges</u></p> <p>90%</p>

SCHEDULE OF COVERED EXPENSES

BENEFITS and PROVISIONS	RHC Facilities	In-Network	Out-of-Network
Outpatient Physical Therapy <i>Limited to \$3,000 per incident or occurrence. However, additional benefits payable if medically necessary.</i>	<u>Facility Charges Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility Charges</u> 90%
Outpatient Speech Therapy <i>Limited to \$3,000 per incident or occurrence. However, additional benefits payable if medically necessary.</i>	<u>Facility Charges Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility Charges</u> 90%
Emergency Care	100%		
Inpatient Hospital Services <ul style="list-style-type: none"> ▪ Room and board not to exceed the semi-private room rate (80% of private room rate if only private rooms available) ▪ Necessary services and supplies including an intensive care unit and a cardiac care unit 	<u>Facility Charges Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility Charges</u> 90%
Extended Care Facility (A.K.A. Skilled Nursing Facility)– Includes: <ul style="list-style-type: none"> ▪ room, board and floor nursing care (up to the facility's semi-private room rate, and limited to a maximum of 60 days per Person, per Calendar Year) <i>Admit within 14 consecutive days following termination of Inpatient Hospital stay of at least three (3) consecutive days.</i> <i>Does not apply to Out of Pocket Maximums</i>	50%	50%	50%
Routine Cancer Care (due to terminal condition related to cancer) <i>Limited to services which constitute routine patient care pursuant to the Covered Person's participation in an approved cancer research trial.</i>	<u>Facility Charges Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility Charges</u> 90%
Outpatient Hospital Services	<u>Facility Charges Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility Charges</u> 90%
Surgery (Inpatient/Outpatient)	<u>Facility Charges Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility Charges</u> 90%
Cardiac Rehabilitation (must be after cardiac surgery)	<u>Facility Charges Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility Charges</u> 90%

SCHEDULE OF COVERED EXPENSES

BENEFITS and PROVISIONS	RHC Facilities	In-Network	Out-of-Network
Second Surgical Opinion		100%	<u>Deductible Waived</u>

BENEFITS and PROVISIONS	RHC Facilities	In-Network	Out-of-Network
Mental Health Services (<i>Mental/Nervous, Substance Abuse</i>)			
<ul style="list-style-type: none"> ▪ <i>Includes facility charges and psychiatric service charges of a Physician for nervous, mental or substance abuse disorder treatment subject to the applicable maximum as shown below.</i> ▪ <i>Expenses apply to Deductible and Out-of-Pocket Expense Limit.</i> 			
Inpatient Mental/Nervous, Substance Abuse <ul style="list-style-type: none"> ▪ <i>45 day maximum (combined Mental Nervous, Substance Abuse) per Calendar Year</i> ▪ <i>Partial confinement programs are covered included in 45 day maximum</i> 	<u>Facility Charges Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility Charges</u> 90%
Outpatient Mental/Nervous , Substance Abuse <ul style="list-style-type: none"> ▪ <i>60 visits maximum per Calendar Year</i> <i>Medication management visits do not count towards the Mental Nervous maximums and are payable as any other illness.</i>	N/A	<u>Non-Facility Charges</u> 100%	<u>Non-Facility Charges</u> 90%

SCHEDULE OF COVERED EXPENSES

BENEFITS and PROVISIONS	RHC Facilities	In-Network	Out-of-Network
Other Covered Services/Items <i>(see below)</i> <i>Note that all services listed will be subject to provisions of any previously listed categories and that not all services are available under all levels of coverage.</i>	<u>Facility Charges</u> <u>Only</u> 100%	<u>Facility Charges</u> 90% <u>Non-Facility</u> <u>Charges</u> 100%	<u>Facility Charges</u> 50% <u>Non-Facility</u> <u>Charges</u> 90%

OTHER COVERED SERVICES/ITEMS

Please read Certificate of Insurance for detailed information regarding the coverage of services/items in and out of network.

Pre-Admission Testing
Anesthesia and Its Administration <i>(Inpatient/Outpatient)</i>
Ambulatory Surgical Center Care
Diagnostic X-ray and Laboratory Examination
Radium and Radioisotope Treatment
Chemotherapy
Dressings
<i>Purchase and/or rental of Durable Medical Equipment (up to purchase price). Repair or replacement charges are eligible if due to normal wear or a change in the patient's condition (including normal growth)</i>
Dialysis
Hospice
Diabetes <i>self-management training, equipment, supplies and foot care, limited to 3 visits upon initial diagnosis and up to 2 visits upon determination that a significant change in the symptoms have occurred. Includes Medical Nutrition Therapy services</i>
Dental treatment <i>when treatment is for corrective treatment of an Injury within six (6) consecutive months following an Injury to a jaw or sound natural teeth, resulting from an Injury sustained while covered for this benefit. Adjunctive Dental Services are provided to a covered person in a hospital or ambulatory surgical treatment center if 1) Covered Person is a child age 6 or less. 2) Covered Person has an injury or sickness that requires hospital or general anesthesia. 3) Covered Person is disabled</i>
Orthoptic therapy
Covered Medically Necessary Prescription Drugs <i>if not available through the Prescription Drug Card or Mail Order Programs</i>
<i>Processing and administration of Unreplaced Blood and its components</i>
Professional Ambulance Service , <i>from the city or town in which the Employee or covered Dependent becomes disabled, to the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease</i>
<i>Purchasing of Prosthetic Appliances used to aid in the function of or to replace a limb or organ if the appliance is the original appliance or a replacement is required by pathological change or normal growth</i>
Artificial Limbs, Eyes, and Larynx
Casts, Splints, Trusses, Crutches and Braces
First Pair Of Glasses or Contact Lenses , <i>but not both, needed after cataract surgery</i>

OTHER COVERED SERVICES/ITEMS

Home Health Care when treatment is a program of home care that is required as a result of an Injury or Sickness; follows a period of Hospital Confinement; is a result of the Injury or Sickness that was the cause of the Hospital Confinement; and is certified by the attending Physician as a replacement for Hospital Confinement that would otherwise be necessary. Home Health Care includes, but not limited to: services of a Home Health Aide (a person other than an R.N. who provides medical or therapeutic care under the supervision of a Home Health Care Agency). A "Home Health Care Agency means a Hospital agency or other service that is certified by the proper authority of the State in which it is located to provide Home Health Care. The program is not intended to provide benefits for private duty nursing service.

Home Health care is limited to 40 visits per Person, per Calendar Year maximum.

Maternity Services (Including Complications) payable as any other illness

Voluntary Sterilization

Diagnosis and Treatment of Medical Problems that Contribute to the Condition of Infertility, but not any charges in connection with the promotion of conception.

**Infertility Services are covered for Covered Persons of participating Employers with 26 or more employees.*

Pre-Service Review

The following surgical procedures are generally not covered by the Program unless they are Medically Necessary. Accordingly, it is strongly recommended that a pre-service review of the following surgical procedures be obtained to establish, before surgery, the Medical Necessity of the services and to determine, in advance, the benefits, if any, which may be available from the Program. Procedures for which pre-service review are recommended are:

- a) Blepharoplasty (eyelid surgery)*
- b) Lipectomy or Liposuction (removal of fat tissue)*
- c) Rhinoplasty (nose bone surgery)*
- d) Mammoplasty (breast augmentation or reduction)*
- e) Scar revision procedures.*
- f) Vein surgeries or injections.*
- g) Ear lobe surgeries.*
- h) Derma or Chemo Abrasion procedures.*
- i) Pulse dye or other laser treatment for vascular abnormality.*
- j) Kerato-refractive surgeries (eye surgery which changes the shape of the eye in order to correct nearsightedness, farsightedness or astigmatism).*
- k) Genetic testing.*
- l) Bariatric bypass surgery.*

If a Covered Person is advised that surgery may be necessary for one of the procedures listed above, the procedures below should be followed in order to determine whether such surgery is covered by the Program.

The Covered Person or Physician should call the Administrator before the surgery. A questionnaire will be sent to the Physician which, when completed and returned to the Administrator, will provide the information necessary to determine if any benefits are payable for the service contemplated. The Administrator will then notify the Covered Person of the outcome of the pre-service review.

The Covered Person is free to follow the advice of any Physician. However, if a pre-service review reveals that the surgery is not a Covered Expense, benefits are not payable hereunder.

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