SELECT EXCLUSIVE PLAN SCHEDULE

COVERED EXPENSES	PARTICIPANT SHARE OF COST
	San Joaquin General Hospital (Health Care Services)
Deductible (applies to all services except doctor's office visits and prescription drugs) per Plan Year	$125 per person $250 per family
Acupuncture/Chiropractor • Up to 20 visits combined per Plan year	Deductible applies Plan pays up to $25 per visit (does not apply to out-of-pocket maximum)
Alcohol and Drug Dependency • Outpatient Treatment	$5 co-payment per visit
• Inpatient Treatment	Deductible applies
Ambulance • Covered if emergency or pre-authorized	Deductible applies
Chiropractor/Acupuncture • Up to 20 visits combined per Plan year	Deductible applies Plan pays up to $25 per visit (does not apply to out-of-pocket maximum)
Doctor Office Visit – Non-preventive • Physical Exam • In-office consultation by specialist • Hearing Tests – up to age 18 • Allergy Testing or treatment	$5 co-payment per visit
Durable Medical Equipment, Orthotics or Prosthetics	Deductible applies 50% for least expensive of purchase, rental or repair (does not apply to out-of-pocket maximum)
Emergency Room • Hospital facility charge – waived if admitted	Deductible applies plus $40 co-payment per admission
• Emergency Room Physician	Deductible applies

SELECT EXCLUSIVE PLAN SCHEDULE

COVERED EXPENSES	PARTICIPANT SHARE OF COST
	San Joaquin General Hospital (Health Care Services)
Home Health • Maximum 60 days per condition combined with Skilled Nursing Facility	Deductible applies
Hospice • 6 months, renewed as necessary	Deductible applies
Hospital Inpatient or ICU • Hospital Inpatient services and supplies	Deductible applies
• Surgeon, assistant surgeon and/or anesthesiologist	Deductible applies
• Hospital or Skilled Nursing Facility doctor visit	Deductible applies
Immunization	$10
Infertility Treatment	Deductible applies 50% (does not apply to out-of-pocket maximum)
Laboratory Services	Deductible applies
Mental Health • Outpatient Therapy	$5 co-payment per visit
• Inpatient/Day Care	Deductible applies
Outpatient Surgery	Deductible applies
Prescription Drugs (Outpatient) • Generic mandatory when available. • 30-day supply • Does not apply to out-of-pocket maximum	$5 Generic $15 Brand on Formulary Non-formulary not covered

SELECT EXCLUSIVE PLAN SCHEDULE

COVERED EXPENSES	PARTICIPANT SHARE OF COST
	San Joaquin General Hospital (Health Care Services)
Prescription Drugs (Outpatient – continued) • 90-day supply at pharmacy or mail order • Does not apply to out-of-pocket maximum	 $10 Generic $30 Brand on Formulary Non-formulary not covered
Preventive Care Services Recommended under the Affordable Care Act	No charge
Rehabilitation Therapy (Physical, Speech or Occupational Therapy)	Deductible applies plus $10 co-payment per visit
Skilled Nursing Facility • Maximum 60 days per condition combined with Home Health	Deductible applies
Urgent Care Center	Deductible applies plus $40 co-payment per visit
X-rays	Deductible applies

PLAN MAXIMUMS	
Maximum Out-of-Pocket Does not include non-covered services, unauthorized services, charges in excess of contract or allowable rates; or your share of cost for prescriptions, chiropractic/ acupuncture care, infertility treatment, and durable medical equipment.	• $1,000 per person • $2,500 per family • Once the annual maximum is met, this Plan pays 100% of eligible expenses for the balance of the Plan Year.
Maximum Benefits Paid for Each Participant	• No Lifetime Limit

Non-Grandfathered Health Plan

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet health care reforms legislated by the Act. Specifically, this Plan must provide preventive services and screenings to you without any cost sharing when the services are performed by a Participating Provider; and emergency services performed by Participating and non-participating providers in an emergency department of a hospital are subject to the same coinsurance and copayment.