



PPO BENEFIT PLAN C7

Copay
Deductible
Coinsurance Level
Individual Calendar Year Out-Of-Pocket
\$5,000,000 Combined Lifetime Maximum

\$20 Network	
\$1,000 Network	\$3,000 Non-network
80% Network	60% Non-network
\$5,000 Network	\$15,000 Non-network

Preventive Care*

- Routine physical exams
- Pap smears
- Prostate screenings
- Routine immunizations
- Mammograms

Network: \$20 copay, then 100% to a \$300 calendar year maximum (one copay covers the office visit, x-ray, and lab tests if billed by the attending network physician) per member

Non-network: Deductible then 80% coinsurance to a \$300 calendar year maximum per member

Physician Services

- Office, hospital visits (excluding psychiatric services)
- Therapy, x-ray, or lab tests

Network: \$20 copay, then 100% (one copay covers the office visit, x-ray, and lab tests if billed by the attending network physician)

Non-network: Deductible then 80% coinsurance

Physician Surgery & Anesthesiology

Applicable deductible then coinsurance

Hospital

- Inpatient facility charges
- Outpatient facility charges

Applicable deductible then coinsurance

- Outpatient facility diagnostic service (includes x-ray and lab tests and excludes mammograms)

Applicable deductible then coinsurance

- MRI-CAT scans

Applicable deductible then coinsurance

- Urgent care centers

Network: \$30 copay, then 100% coinsurance
Non-network: \$60 copay, then 100% coinsurance

- Emergency room (copay waived if immediately confined)

Network: \$100 copay, then coinsurance
Non-network: \$200 copay, then coinsurance

Maternity

- Prenatal care (included for groups with 15+ employees, optional for groups with 2-14 employees)

Applicable deductible then coinsurance

Ambulance

Ground: \$100 copay, then 80% coinsurance
Air: \$200 copay, then 80% coinsurance

Prescription Drug

- Retail 30-day supply
- Includes a mail-order benefit

Generic: \$15 copay
Brand-name: \$25 copay plus 10% of remaining cost (listed on formulary/preferred drug list)
Brand-name: \$40 copay plus 20% of remaining cost (not listed on formulary/preferred drug list)

***Mandated Preventive Care:** State mandated benefits (childhood immunizations, mammograms, women’s preventive health services) will be covered at the mandated levels or at our benefit level whichever is greater/higher.

Maximum Allowable Charge: The insured person may be subject to additional charges (above copays, deductibles, and coinsurance) if the billed amount is deemed to be above the maximum amount we would consider eligible for payment for non-network benefits.

Travelcare Benefit: TravelCare is an extended network provider benefit which allows insureds who are traveling outside of their networks’ primary service area to receive care from providers affiliated with Private Healthcare Systems, Inc. (PHCS), a nationwide PPO network (preferred provider organization). Receive care from a PHCS provider and get network-level coverage—that may mean less out-of-pocket expense!

This is an outline only and not intended to serve as legal interpretation of benefits. This is not a complete solicitation of health insurance. The Group Products brochure, (BR-0382-31-1-TG) further describes state specific benefits and other coverages. However the contract language stands alone and the complete terms of the coverage will be determined by the Group Policy # PO-B001-31-1-TG 6/01 or PO-C001-31-1-TG 11/02.

LIMITATIONS AND EXCLUSIONS

Medical Limitations

Unless specified as a covered benefit medical insurance coverage is limited for:

- alternative or complementary medicine
- birth control
- care furnished by a government plan or facility
- complications resulting from a not-covered expense
- cosmetic surgery
- court-ordered treatment
- cutting, removal or treatment of corns, calluses or toenails
- emergency room care if there is no emergency
- hospital admission on a Friday, Saturday, or Sunday
- intentional self-inflicted injury, or attempted suicide
- manipulative therapy
- medical food coverage to \$5,000 per calendar year
- medical services to participate in sports-related activities
- on-the-job injury or sickness if Workers' Compensation is in effect
- organ transplant surgery travel benefit
- pre-existing conditions
- routine eye or vision exams
- routine injection of drugs and immunizations, beyond age 18
- services received outside the U.S.
- standby doctors
- transitional or residential living
- treatment of alcoholism, substance abuse, mental or nervous disorders, and serious mental illnesses
- treatment for learning disabilities; testing or training for school or vocation; speech therapy and testing

Medical Exclusions

No medical insurance coverage is provided for any of the following:

- any medical services for jaw-joint problems
- by law must be provided by an educational institution
- charges in excess of the maximum allowable charge
- charges for growth treatments and medications including but not limited to growth hormones
- charges to complete claim forms or finance charges
- complications from discontinuing treatment against a doctor's written orders
- custodial care to assist in daily living needs or services
- dental treatment including but not limited to chewing injuries or dental implants

- educational materials or presentations
- exercise equipment or programs
- expense for which no benefit is defined or described
- experimental or investigative procedures, devices, services, supplies, or drugs
- genetic testing, treatment, therapy, or counseling
- hearing exams or hearing aids and their fitting
- injury or sickness caused by war, military service, commission of a civil or criminal battery or felony, taking part in a riot, engaging in an illegal occupation
- items used primarily for comfort or generally used in the household, such as a humidifier
- marriage or family counseling and sex therapy
- medical services free of charge without this coverage
- missed or broken appointments
- outpatient prescriptions, unless included in the plan
- private-duty nursing services
- replacement batteries
- routine physical exams and related medical services, unless included in the plan
- sclerotherapy of varicose veins
- services not documented in medical records
- services not rendered
- services provided by a family member
- services rendered when coverage is not in effect
- services and supplies that are not medically necessary, not ordered by a doctor, not rendered within the scope of a doctor's license
- services and supplies for hair loss or hair growth, such as hair transplants and wigs
- sex change operations or complications, artificial insemination or fertilization, testing and treatment for impotency or infertility, elective abortion, sterilization reversal
- storage of blood products unless approved by us; or blood products that are replaced by donation
- surgery to correct eyesight, such as radial keratotomy
- telemedicine services
- treatment for myofascial pain syndrome or related conditions
- treatment for strained or flat feet, instability or imbalance of feet or ankles including orthopedic shoes
- treatment for tobacco or nicotine addiction
- treatment, procedure, program, membership dues or clinics for weight loss

PPO: A network of credentialed doctors, clinics, hospitals and other health care facilities that are contracted to provide medical services at negotiated fees. See your agent and/or go to eAMS.com website for a listing of participating providers, which may include your doctor.

Network providers are compensated for each service covered under the Policy at a predetermined rate. The predetermined rates are usually less than the rates customarily charged by the network provider. AMS may replace the network at any time. Advance notice will be given.

Copayment or Copay: A fixed fee paid by the insured for specific services. Copays do not apply toward deductibles or the out-of-pocket maximum.

Deductible: The amount of covered expenses paid each calendar year by the insured before benefits are paid under the Policy.

Coinsurance: The insurance company and the insured share a percentage of covered expenses to a maximum limit after the deductible has been met. Once the maximum limit has been met the insurer pays 100% of covered expenses for the remainder of the calendar year.

Individual Network Out-of-Pocket: \$1,000 deductible + [20% (your coinsurance responsibility) x \$20,000 (your coinsurance limit)] = \$5,000

Individual Non-network Out-of-Pocket: \$3,000 deductible + [40% (your coinsurance responsibility) x \$30,000 (your coinsurance limit)] = \$15,000

The family out-of-pocket maximum is 2 times the individual amount. The family deductible is 3 times the individual amount for any deductible under \$500. For all other deductible levels, the family deductible will be 2 times the individual deductible.

Insurance Products

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