

**CITY OF LAKE WALES - SCHEDULE OF MEDICAL, VISION, AND DENTAL BENEFITS**  
**Effective 1/1/2007**

<b>Medical Benefits Payable</b>	<b>Select Network Provider</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Individual Lifetime Maximum Benefit</b> While covered under this Plan for Participating and/or Non-Participating Provider Benefits	\$1,000,000		
<b>Calendar Year Medical Deductible</b>			
Per Individual	\$500	\$500	\$1,000
Per Family, Per Calendar Year (Cumulative)	\$1,000	\$1,000	\$2,000
Hospital Inpatient Deductible	none	\$500	\$500
<b>Percentage Payable</b> (after Deductible/Copayment)	80%	70%	50%
Balance of Covered Expenses after Out-of-Pocket limit has been met	100%	100%	100%
<b>Out-of-Pocket Expense Limits (including deductible)</b>			
Per Individual	\$3,500	\$5,000	\$7,000
Per Family (Cumulative)	\$7,000	\$10,000	\$14,000
<b>NOTE: Out-of-area/Medical Emergencies will be payable at the lesser of \$50.00 per occurrence or 50% of the Usual and Reasonable Charge. Services that are not available at the Select Network will be payable at the Select Network rate when the basic Network is utilized (prior approval will be required).</b>			
<b>Physician Office Visits</b>			
Benefits Payable	\$25.00 copay	\$30.00 copay	50%
This benefit applies to all services rendered in a Participating Physician's Office, minor surgical procedures, laboratory work and x-rays.			
<b>Special Benefits</b>			
<b>Physician Services</b>			
Surgical Expenses	80%	70%	50%
Voluntary Second Surgical Opinion	\$25.00 copay	\$25.00 copay	50%
Pre-admission Testing	80%	70%	50%
Birthing Center	80%	70%	50%
<b>Hospital Daily Room and Board</b> (Limited to the average semiprivate room rate)	80%	70%	50%
Percentage Payable (after deductible/copayment)	deductible waived		
<b>Intensive Care Unit</b> (Limited to 3 times the avg semiprivate room rate)	80%	70%	50%
Percentage Payable (after deductible/copayment)	deductible waived		
<b>DISCOUNT FOR LAKE WALES HOSPITAL IS 35% INPATIENT AND 30% OUTPATIENT</b>			
<b>Hospital Out-patient Services</b> All Outpatient Services excluding Surgical Procedures (Waive deductible)	100%	70%	50%
<b>Hospital Out-patient Surgery Facility Fee</b> Copayment per incident (After Copay, then 100%) (After copay, then 100%)	100% no copay	\$500 copay then 100%	\$1,000 copay then 100%
<b>Hospital Emergency Room</b>			
Medical Emergency (after deductible/copayment)	80%	70%	50%
Non-Emergency Use (after deductible/copayment)	65%	50%	50%
Copayment	\$25.00	\$25.00	N/A
<b>Skilled Nursing Facility</b> (limited to the facility's Usual and Reasonable Charge) Maximum benefit payable	80% 60 days per Calendar Year	70% 60 days per Calendar Year	50% 60 days per Calendar Year
<b>Home Health Care</b>			
Percentage Payable	80%	70%	50%
Calendar Year maximum	40 visits	40 visits	40 visits
<b>Outpatient Private Duty Nursing</b>			
Percentage Payable	80%	70%	50%

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<b>Hospice Care</b>			
Inpatient	\$150 per day; \$3,000 lifetime max	\$150 per day; \$3,000 lifetime max	\$150 per day; \$3,000 lifetime max
Outpatient	\$50 per day; \$2,000 lifetime max	\$50 per day; \$2,000 lifetime max	\$50 per day; \$2,000 lifetime max
<b>Ambulance</b>			
Percentage Payable To nearest facility	80%	70%	50%
<b>Wig after Chemotherapy</b>			
Percentage Payable	80%	70%	50%
<b>Chemotherapy/Radiation</b>			
Copayment per course of Treatment	\$250 copay then 80% waive deductible	\$250 copay then 80% waive deductible	\$500 copay then 50% waive deductible
<b>Occupational Therapy</b>			
Percentage Payable	80%	70%	50%
<b>Physical Therapy</b>			
Percentage Payable Calendar Year maximum	80% 20 visits	70% 20 visits	50% 20 visits
<b>Speech Therapy</b>			
Percentage Payable Calendar Year maximum	80% 20 visits	70% 20 visits	50% 20 visits
<b>Durable Medical Equipment</b>			
Percentage Payable	80%	70%	50%
<b>Prosthetics/Orthotics</b>			
Percentage Payable	80%	70%	50%
<b>Infertility Treatment</b>			
Percentage Payable	80% of the first \$2,000 of covered charges incurred and 50% thereafter	70% of the first \$2,000 of covered charges incurred and 50% thereafter	50% of the first \$2,000 of covered charges incurred and 40% thereafter
<b>Spinal Manipulation</b>			
Percentage Payable Calendar Year maximum Copayment	80% 20 visits \$25.00 per visit	70% 20 visits \$25.00 per visit	50% 20 visits \$25.00 per visit
<b>Pregnancy</b> (Dependent daughters NOT covered)	80% after deductible	70% after deductible	50% after deductible
<b>Organ Transplants</b>	80% after deductible \$150,000 per organ lifetime maximum	70% after deductible \$150,000 per organ lifetime maximum	50% after deductible \$150,000 per organ lifetime maximum
<b>Preventative Care</b>			
Routine Well Adult Care	100% after \$25 copay \$500 Calendar Year Maximum	100% after \$30 copay \$200 Calendar Year Maximum	50% after deductible \$200 Calendar Year Maximum
Includes: Mammogram & gynecological exam Frequency limits for mammogram Ages 35 through 39 ..... Ages 40 through 49 ..... Ages 50 and over .....	Single baseline Mammogram every two years annually		
<b>Routine Well Newborn Care</b>	80% after deductible	70% after deductible	50% after deductible
<b>Routine Well Child Care</b>			
Includes: routine physical examination, laboratory blood tests, x-rays and immunizations through age 16	100% after \$25 copay \$500 Calendar Year Maximum	100% after \$30 copay \$200 Calendar Year Maximum	50% after deductible \$200 Calendar Year Maximum

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<b>Mental Disorders and Substance Abuse</b>			
Inpatient	100% after \$250 per confinement deductible; 30 days Calendar Year maximum	100% after \$250 per confinement deductible; 30 days Calendar Year maximum	100% after \$250 per confinement deductible; 30 days Calendar Year maximum
Outpatient	100% after \$20.00 copay per visit; 30 days Calendar Year maximum	100% after \$20.00 copay per visit; 30 days Calendar Year maximum	100% after \$20.00 copay per visit; 30 days Calendar Year maximum
<p>MENTAL DISORDERS/SUBSTANCE ABUSE TREATMENT LIMITS ARE COVERED THROUGH BRADMAN UNIPSYCH. Please call 1-800-272-3626 as Pre-certification is required for all services rendered for Mental Disorders/Substance Abuse and EAP.</p>			
<b>Prescription Drug Benefit</b> Maximum Supply - 30 days	<p>\$10 copay - Generic                  \$25 copay - Multi-Brand                  \$50 copay - Single Source Brand</p>		
<b>Mail-Order Prescription Drug Coverage</b> Minimum Supply - 14 days Maximum Supply - 90 days	<p>\$10 copay - Generic                  \$25 copay - Multi-Brand                  \$50 copay - Single Source Brand</p>		
<b>Vision Care Benefits</b>			
Eye exam, per person in a 12-month period ..... \$75.00			
All other covered services in a 12-month period ..... \$200.00			

<b>Vision Benefits</b>	
Calendar Year Maximums	
Eye Exam	\$75
All other covered services	\$200
<b>Dental Benefits</b>	
Calendar Year Deductible per person	\$50
Deductible applies to all Classes of Services, except Class A	
Dental Percentage Payable	
Class A - Preventative	100%
Class B - Basic	80%
Class C - Major	50%
Class D - Orthodontia	50%
Maximum Benefit Amount	
All Classes of Covered Services	\$1,000