

Care CoordinationSM

When we are notified as required, we will work with you to implement the Care CoordinationSM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the notification requirements described below do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to notify us before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. The Annual Deductible for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i>.</p>	<p>Network</p> <p>For single coverage, the Annual Deductible is \$2,500 per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$5,000. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.</p> <p>Non-Network</p> <p>For single coverage, the Annual Deductible is \$6,000 per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$12,000. No one in the family is eligible to receive Benefits until the family Annual Deductible is</p>

Payment Term And Description	Amounts
	satisfied.
Out-of-Pocket Maximum	
<p>The maximum you pay per year for the Annual Deductible, or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. The Out-of-Pocket Maximum for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i>.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not notify us as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> that does not apply to the Out-of-Pocket Maximum. 	<p>Network</p> <p>For single coverage, the Out-of-Pocket Maximum is \$5,000 per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$10,000.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p> <p>Non-Network</p> <p>For single coverage, the Out-of-Pocket Maximum is \$10,000 per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$20,000.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p>
Maximum Policy Benefit	
<p>The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.</p>	<p>Network</p> <p>No Maximum Policy Benefit.</p> <p>Non-Network</p> <p>No Maximum Policy Benefit.</p>
Copayment	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of</i></p>	

Payment Term And Description	Amounts
<i>Benefits.</i>	
Coinsurance	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits.</i></p>	

Benefit Limits

This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits.*

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Ambulance Services			
Pre-service Notification Requirement			
<p>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify us as soon as possible prior to transport. If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Emergency Ambulance	Network <i>Ground Ambulance:</i> 80% <i>Air Ambulance:</i> 80%	Yes Yes	Yes Yes
	Non-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	Network <i>Ground Ambulance:</i> 80% <i>Air Ambulance:</i> 80%	Yes Yes	Yes Yes
	Non-Network Same as Network	Same as Network	Same as Network
2. Clinical Trials			
Pre-service Notification Requirement			
<p>You must notify us as soon as reasonably possible if participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
Benefits are available when the Covered Health Services are provided by either Network or non-Network	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
providers, however if the non-Network provider does not agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial, you will be responsible for the difference and may be billed by the non-Network provider.	each Covered Health Service category in this <i>Schedule of Benefits</i> .		
3. Congenital Heart Disease Surgeries			
Pre-service Notification Requirement			
For Non-Network Benefits you must notify us as soon as reasonably possible if a Congenital Heart Disease (CHD) surgery arises. If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses.			
Network and Non-Network Benefits under this section include only the Congenital Heart Disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Benefits are limited to \$30,000 per CHD surgery.	Network 80% Non-Network 60%	Yes Yes	Yes Yes
4. Dental Services - Accident Only			
Pre-service Notification Requirement			
You must notify us five business days or as soon as reasonably possible before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.) If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 80% Non-Network Same as Network	Yes Same as Network	Yes Same as Network

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
5. Diabetes Services			
<p style="text-align: center;">Pre-service Notification Requirement</p> <p>For Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either purchase price or cumulative rental of a single item). If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
6. Diabetes Treatment			
<p>Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.</p> <p>Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
7. Durable Medical Equipment			
Pre-service Notification Requirement			
For Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either purchase price or cumulative rental of a single item). If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.			
<p>Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to orthotic appliances.</p> <p>To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.</p>	<p>Network 80%</p> <p>Non-Network 60%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
8. Emergency Health Services - Outpatient			
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p>	<p>Network 80%</p>	<p>Yes</p>	<p>Yes</p>

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network Same as Network	Same as Network	Same as Network
9. Hearing Aids			
Limited to \$2,500 per year.	Network 80%	Yes	Yes
	Non-Network 60%	Yes	Yes
10. Home Health Care			
Pre-service Notification Requirement			
For Non-Network Benefits you must notify us five business days before receiving services or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to 100 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	Network 80%	Yes	Yes
	Non-Network 60%	Yes	Yes
11. Hospice Care			
Pre-service Notification Requirement			
For Non-Network Benefits you must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network 80%	Yes	Yes
	Non-Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	60%	Yes	Yes
12. Hospital - Inpatient Stay			
<p style="text-align: center;">Pre-service Notification Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p>			
	Network 80% Non-Network 60%	 Yes Yes	 Yes Yes
13. Lab, X-Ray and Diagnostics - Outpatient			
	Network 80% Non-Network 60%	 Yes Yes	 Yes Yes
14. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	Network 80% Non-Network 60%	 Yes Yes	 Yes Yes
15. Mental Health and Substance Abuse Services - Inpatient and Intermediate			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits</p>			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
will be paid.			
	Network 80%	Yes	Yes
	Non-Network 60%	Yes	Yes
16. Mental Health and Substance Abuse Services - Outpatient			
Prior Authorization Requirement			
You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.			
	Network 80%	Yes	Yes
	Non-Network 60%	Yes	Yes
17. Ostomy Supplies			
	Network 80%	Yes	Yes
	Non-Network 60%	Yes	Yes
18. Pharmaceutical Products - Outpatient			
	Network 80%	Yes	Yes
	Non-Network 60%	Yes	Yes
19. Physician Fees for Surgical and Medical Services			
	Network 80%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 60%	Yes	Yes
20. Physician's Office Services - Sickness and Injury			
	Network 80%	Yes	Yes
	Non-Network 60%	Yes	Yes
21. Pregnancy - Maternity Services			
Pre-service Notification Requirement			
<p>For Non-Network Benefits you must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
	<p>Network</p> <p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p> <p>Non-Network</p> <p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p>		
22. Preventive Care Services			
Physician office services	Network 100%	No	No
	Non-Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Lab, X-ray or other preventive tests</p> <p>We pay for Covered Health Services incurred if you participate in the Expanded Alpha Feto Protein (AFP) program, a statewide prenatal testing program administered by the State Department of Health Services.</p>	<p>Non-Network Benefits are not available.</p> <p>Network</p> <p>100%</p> <p>Non-Network</p> <p>Non-Network Benefits are not available.</p>	<p>Non-Network Benefits are not available.</p> <p>No</p> <p>Non-Network Benefits are not available.</p>	<p>Non-Network Benefits are not available.</p> <p>No</p> <p>Non-Network Benefits are not available.</p>
23. Prosthetic Devices			
	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>60%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
24. Reconstructive Procedures			
<p align="center">Pre-service Notification Requirement</p> <p>For Non-Network Benefits you must notify us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Pre-service Notification Requirement			
<p>For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p>			
Limited to 60 days per year.	Network 80% Non-Network 60%	 Yes Yes	 Yes Yes
28. Surgery - Outpatient			
	Network 80% Non-Network 60%	 Yes Yes	 Yes Yes
29. Temporomandibular Joint Disorder (TMJ) Services			
Pre-service Notification Requirement			
<p>You must notify us five business days or as soon as reasonably possible before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.</p>			
Covered Services are payable in the same manner as surgery for other covered medical conditions except that benefits for treatment of TMJ are limited to \$3,000 during the entire period of time you are covered under the Policy.	Network Same as Hospital-Inpatient Stay, Surgery-Outpatient. Non-Network	 Yes	 Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	60%	Yes	Yes
30. Therapeutic Treatments - Outpatient			
Pre-service Notification Requirement			
For Non-Network Benefits you must notify us for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require notification: dialysis. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 80%	Yes	Yes
	Non-Network 60%	Yes	Yes
31. Transplantation Services			
Pre-service Notification Requirement			
For Network Benefits you must notify us as soon as reasonably possible if a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify us and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply.			
For Non-Network Benefits you must notify us as soon as reasonably possible if a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	Network 80%	Yes	Yes
Non-Network Benefits are limited to \$30,000 per transplant.	Non-Network 60%	Yes	Yes
32. Urgent Care Center Services			
	Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	80% Non-Network	Yes	Yes
	60%	Yes	Yes
33. Vision Examinations			
Limited to 1 exam every 2 years.	Network 80% Non-Network Non-Network Benefits are not available.	Yes Non-Network Benefits are not available.	Yes Non-Network Benefits are not available.
Additional Benefits Required By California Law			
34. Dental Services – Inpatient			
<p>Pre-service Notification Requirement</p> <p>You must notify us five business days or as soon as reasonably possible before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.) If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
Services are limited to Covered Persons who are one of the following: <ul style="list-style-type: none"> • A child under seven years of age. • A person who is developmentally disabled, regardless of age. • A person whose health is compromised and for whom general anesthesia is required, regardless of age. 	Network 80% Non-Network 60%	Yes Yes	Yes Yes
35. Mastectomy Services			
Network Depending upon where the Covered Health Service is			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
36. Medical Foods			
Limited to Formulas and Special Food Products prescribed by a Physician for the treatment of phenylketonuria (PKU).	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>60%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
37. Mental Health Services-Severe Mental Illness and Serious Emotional Disturbances			
<p>Prior-Authorization Requirement</p> <p>You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
38. Osteoporosis Services			
	<p>Network</p> <p>Depending upon where the Covered Health Service is</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
39. Prosthetic Devices – Laryngectomy			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
40. Telemedicine Services			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.