Schedule Of Benefits Summary
Health Benefits
Educators Health Alliance $350 Deductible

	IN-NETWORK	OUT-OF-NETWORK
Maximum Benefits Per Covered Person		
Overall Maximum	$5,000,000	
Your Calendar Year Deductible		
Individual	$350	$700
Family (embedded)*	$700	$1,400
The calendar year deductible is applicable before benefits begin, unless otherwise noted.		
Maximum Coinsurance Limit		
Individual	$2,000	$4,000
Family embedded*	$4,000	$8,000
Inpatient Facilities**		
Hospital Care	20%	40%
Long Term Acute Care	20%	40%
Skilled Nursing Facility *(30-day per person calendar year maximum)*	20%	40%
Outpatient Facilities		
Hospital Outpatient	20%	40%
Other Outpatient Facility	20%	40%
Emergency Room (facility/physician)	20%	40%
Emergency Room (if admitted to the hospital)	20%	40%
Urgent Care (facility)	20%	40%
Cardiac/Pulmonary Rehabilitation *(certification required for pulmonary)*	20%	40%
Physician Services		
Physician Office Visit Charge	$35 Copay	40%
Specialist Office Services	$35 Copay	40%
Other Covered Physician Services	20%	40%
Urgent Care (professional)	$35 Copay	40%
[NOTE: If more than one physician is seen on the same day, each physician will be accessed a separate copay.]		
Pregnancy and Maternity		
Pre/post Natal Care and Delivery	20%	40%
Routine/Preventive Care Services Through Age Four - No Dollar Maximum		
Exam, Office Visit	Subject to Coinsurance Only	Subject to Coinsurance Only
Radiology/X-ray, Pathology/Lab	Subject to Coinsurance Only	Subject to Coinsurance Only
Routine/Preventive Care Services Age Five and Above $500 per Calendar Year Per Covered Person		
Exam, Office Visit	20%	40%
Contraceptive Management	20%	40%
Radiology/X-ray, Pathology/Lab	20%	40%
Cardiac Stress Test	20%	40%

[If you have family coverage, no one family member contributes more than the individual amount to satisfy the family amount.]*

*[** Certification requirements apply. 25% penalty may apply for failure to comply.]*

	IN-NETWORK	OUT-OF-NETWORK
[*The following routine/preventive care services are not subject to the calendar year maximum*]		
Prostate specific antigen (Including corresponding professional and technical fees).	Not subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Immunizations, *non-pediatric* (routine)	Not subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Immunizations, *pediatric*	Not subject to Deductible and Coinsurance	Subject to Coinsurance Only
Mammograms(preventive) (Including corresponding technical and professional fees)	Not subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Pap Smears (preventive) (Including corresponding technical and professional fees)	Not subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Other Covered Services		
Ambulance	20%	40%
Home (Durable) Medical Equipment	20%	40%
Home Health Aide *(60-day per person calendar year maximum)*	20%	40%
Skilled Nursing Care	20%	40%
Respiratory Care *(60-day per person calendar year maximum)*	20%	40%
Hospice *(certification required)*	20%	40%
TMJ and Craniomandibular *($2,500 contract maximum)*	20%	40%
Spinal Manipulations and Adjustment *(30 session per person calendar year maximum)*	20%	40%
Physical, Occupational or Speech Therapy *(60 session per person calendar year maximum combined)*	20%	40%
Miscellaneous Covered Services	20%	40%
Mammography/Pap Smears/Immunizations *(excluding routine)*	20%	40%
Colonoscopy, sigmoidoscopy, barium enema, etc	20%	40%
Independent Lab	20%	40%
Mental Illness and Substance Abuse		
Inpatient (facility and professional)	20%	40%
Outpatient Services	20%	40%
Emergency Room (facility/physician)	20%	40%

***[Remember:** If you use an out-of-network provider, you will be responsible for amounts in excess of the Allowable Charge in addition to the applicable copay, deductible and/or coinsurance amounts.]*