

WARD MANUFACTURING HEALTH PLAN

SCHEDULE OF MEDICAL BENEFITS

Maximum Lifetime Benefit for PPO Medical Care **Unlimited**
Maximum Lifetime Benefit for Non-PPO Medical Care **\$1,000,000**

	PPO	Non-PPO
Calendar year Deductible:		
Per Covered Person	\$100	\$300
Per Family	\$200	\$600
Benefit Percentage:		
Medical Plan Pays	80%	60%
Covered Person Pays	20%	40%
Out-of-Pocket Maximum:		
Per Covered Person	\$1,000	\$2,000
Per Family	\$2,000	\$4,000

The charges for the following do not accrue to the Out-of-Pocket Maximum and are never reimbursed at 100% by the Plan:

- Mental Health Treatment
- Substance Abuse Treatment

The charges for the following do not accrue to the Out-of-Pocket Maximum:

- Deductible
- Cost Containment Penalties
- Copayments
- Excess Fees
- Expenses incurred for non-covered services

Benefits and Services	In-Network Plan Pays (After Deductible)	Non-Network Plan Pays (After Deductible)	Comments
HOSPITAL BENEFIT			
Inpatient Hospital Services	80% of Allowable Expense	60% of UCR	<i>Pre-notification required</i> Benefit based on Semi-private room rate.
Outpatient Hospital Surgery	80% of Allowable Expense	60% of UCR	
Skilled Nursing Facility	80% of Allowable Expense	60% of UCR	Limited to 100 days each calendar year.
Emergency Room	100% of Allowable Expense after a \$50	100% of UCR	Emergency Room use must be for accidental or life

Benefits and Services	In-Network Plan Pays (After Deductible)	Non-Network Plan Pays (After Deductible)	Comments
	Expense after a \$50 copay Deductible Waived	after a \$50 copay Deductible Waived	threatening injury or illness.
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS			
Inpatient Mental Health Treatment	80% of Allowable Expense	50% of UCR	<i>Pre-notification required</i> Limited to 30 days paid each calendar year.
Outpatient Mental Health Treatment	50% of Allowable Expense	50% of UCR	Limited to 60 visits paid each calendar year.
Inpatient Substance Abuse Treatment	80% of Allowable Expense	60% of UCR	<i>Pre-notification required</i> Limited to 30 days paid per calendar year; lifetime maximum of 90 days.
Inpatient Detoxification	80% of Allowable Expense	60% of UCR	<i>Pre-notification required</i> Limited to 7 days per admission, and to 4 confinements per lifetime.
Outpatient Substance Abuse Treatment	80% of Allowable Expense	60% of UCR	Limited to 30 visits paid per calendar year; lifetime maximum of 120 visits. Participant may exchange two outpatient visits for one inpatient day, limited to 15 inpatient days.
Partial Hospitalization <i>Two partial hospitalization days will apply as one inpatient day.</i>	80% of Allowable Expense	60% of UCR	<i>Pre-notification required</i>
MISCELLANEOUS SERVICES AND SUPPLIES			
Home Health Care	80% of Allowable Expense	60% of UCR	
Hospice Care	80% of Allowable Expense	60% of UCR	Limited to a lifetime maximum of 180 days.
Ambulance Service	80% of Allowable Expense	80% of UCR	Ambulance use must be for accidental or life threatening injury or illness.
Durable Medical Equipment, Orthotics & Prosthetics	80% of Allowable Expense	60% of UCR	Limited to \$2,500 paid each calendar year.
PROFESSIONAL SERVICES BENEFIT			
Physician's visits • Office Visit	100% of Allowable Expense after a \$15 copay per visit	60% of UCR	

Benefits and Services	In-Network Plan Pays (After Deductible)	Non-Network Plan Pays (After Deductible)	Comments
<ul style="list-style-type: none"> Inpatient Hospital Visit or Consultation Allergy Treatment Other Covered Injections 	Deductible Waived 80% of Allowable Expense 80% of Allowable Expense 80% of Allowable Expense	60% of UCR 60% of UCR 60% of UCR	
Second Surgical Opinion	100% of Allowable Expense Deductible Waived	100% of UCR Deductible Waived	
Obstetrics	80% of Allowable Expense	60% of UCR	
Diagnostic Laboratory & X-ray Expenses	80% of Allowable Expense	60% of UCR	
REHABILITATION THERAPY			
Chiropractic Care	80% of Allowable Expense	60% of UCR	Limited to 12 visits each calendar year.
Cardiac Rehabilitation Therapy	80% of Allowable Expense	60% of UCR	Limited to 3 visits per week for 12 weeks each calendar year.
Respiratory Therapy	80% of Allowable Expense	60% of UCR	
Pulmonary Therapy	80% of Allowable Expense	60% of UCR	Limited to 36 visits each calendar year.
Outpatient Therapies <ul style="list-style-type: none"> Speech Therapy Physical Therapy Occupational Therapy 	80% of Allowable Expense	60% of UCR	Limited to a combined 36 visits each calendar year.
PREVENTIVE CARE			
Well Child Care Visits	100% of Allowable Expense after a \$15 copay per visit Deductible Waived	60% of UCR	
<ul style="list-style-type: none"> Birth through age 16 All other Well Child Services. 	80% of Allowable Expense	60% of UCR	Pediatric Immunizations are not subject to the deductible.

Benefits and Services	In-Network Plan Pays (After Deductible)	Non-Network Plan Pays (After Deductible)	Comments
Well Child Care includes reimbursement for the following services: office visits, physical examination, laboratory tests, x-rays, and immunizations.			
Well Adult Care Visits • Age 17+ • All other Well Adult Services.	100% of Allowable Expense after a \$15 copay per visit Deductible Waived 80% of Allowable Expense	60% of UCR 60% of UCR	
Well Adult Care includes reimbursement for the following services: office visits, prostate screening, physical examination, immunizations, x-rays and laboratory tests.			
Gynecological Exam Pap Smear	100% of Allowable Expense after a \$15 copay per visit Deductible Waived 80% of Allowable Expense Deductible Waived	60% of UCR	Limited to one exam each calendar year.
Mammogram Screening	80% of Allowable Expense	60% of UCR	Limited to one screening each calendar year for covered persons over age 40.

PRESCRIPTION DRUG EXPENSE BENEFIT

Pharmacy Option a 30-Day Supply

The Plan provides a prescription drug expense plan. The cardholder is responsible for the applicable co-payment when the card is presented in the participating pharmacy. In order to receive the full benefit of your prescription card you must use a participating pharmacy and present your card.

If you choose to use a non-participating pharmacy or do not have your identification card, you must pay the pharmacy the full amount for the prescription. The pharmacy may complete the section of the direct reimbursement form, which may be obtained from your employer. Once the form is complete forward it to the prescription drug card program with your receipt. You will be reimbursed the amount that would have been paid to the participating pharmacy, less the applicable co-payment.

Pharmacy Co-payment, per Prescription

Generic Drugs. \$15.00

Preferred Brand Drugs (Formulary).....	\$25.00
Non-Formulary Brand Drugs.....	\$50.00

Mail Order Prescription Drug Option a 90-Day Supply

The mail service prescription drug program is available when there is an ongoing need for medication. By using this service, you can obtain prescribed medication required on a non-emergency, extended-use basis. The quantity of a prescribed drug ordered through this program can be anything up to a 90-day supply.

The law requires that pharmacies dispense the exact quantity prescribed by the physician. So if your physician authorizes the maximum order quantity, the prescription must be for a 90-day supply for you to receive that quantity. If your physician authorizes refills, these can be dispensed only when your initial order is nearly exhausted, so be sure to ask your physician to prescribe the normal supply, plus refills whenever appropriate.

When you order by mail, your prescription is reviewed by a pharmacist, checked for drug interactions, dispensed and verified by quality control before it is mailed to you.

Mail Order Co-payment, per Prescription

Generic Drugs	\$30.00
Preferred Brand Drugs (Formulary).....	\$50.00
Non-Formulary Brand Drugs	\$100.00