



SCHEDULE OF BENEFITS

Maximum Benefit Amount \$5,000,000

PPO Network Sagamore Health Network

In-Network Benefits

Calendar Year Deductible

In-Network Individual Deductible Amount \$400

In-Network Family Deductible Amount \$800

In-Network Coinsurance Percentage 90%

Office Visit Copay Amount \$15

Emergency Room Access Fee (in addition to deductible) \$50

In-Network Maximum Coinsurance Share Per Calendar Year

Per Individual \$500

Per Family \$1,000

Out of Network Benefits

Calendar Year Deductible

Out of Network Individual Deductible Amount \$800

Out of Network Family Deductible Amount \$1,600

Out of Network Coinsurance Percentage 70%

Non-preferred Provider Hospital Inpatient Access Fee
(in addition to deductible) \$250

Reasonable & Customary Percentile Level 60th

Out of Network Maximum Coinsurance Share Per Calendar Year

Per Individual \$1,500

Per Family \$3,000

Home Health Care

Maximum Number of Visits per Calendar Year 40

Skilled Nursing Facility	
Maximum Number of Days per Calendar Year	31
Transplant Benefit	
Designated Transplant Facility	100%
Non-designated Transplant Facility	
90% of first \$100,000 after the Deductible	
100% thereafter for the remainder of the Calendar Year	
Prescription Drug Card Benefit	Included
Calendar Year Prescription Deductible	\$50
Prescription Stop Loss Amount	\$3,550
Retail Prescription Copay Amount Before Stop Loss Is Reached	
Generic Prescription Copay Amount	\$15 or 20% of the cost of the drug, whichever is greater
Preferred Brand Prescription Copay Amount	\$25 or 25% of the cost of the drug, whichever is greater
Non-preferred Brand Prescription Copay Amount	\$40 or 40% of the cost of the drug, whichever is greater
Mail Order Prescription Copay Amount Before Stop Loss Is Reached	
Generic Mail Order Prescription Copay Amount	\$20
Preferred Brand Mail Order Prescription Copay Amount	\$50
Non-preferred Brand Mail Order Prescription Copay Amount	\$80
Prescription Copay Amounts After Stop Loss Amount Has Been Reached	
Generic Prescription Copay Amount	\$15
Preferred Brand Prescription Copay Amount	\$25
Non-preferred Brand Prescription Copay Amount	\$40

Optional Benefits

Wellness Benefit for Preventive Health Care (Preferred Provider Only)	Included
Copay Amount for Preventive Health Care Exam	\$15
Maximum Wellness Benefit	\$250
Hospital Benefits for Dental Surgery	Included
Pregnancy Like Any Illness	Included
Infertility & In Vitro Fertilization Benefit	Included
Supplemental Accident Benefit 100% to \$400	Included
Mental Health Parity Benefit	Included
 Federal Continuation of Health Insurance Coverage After Termination	 Included

Precertification

To precertify a hospital stay, please call 1-800-245-3005.

NOTE: Most policies require preauthorization for durable medical equipment and home health. For preauthorization of these types of service please call the case management department at 800-371-9622 dial option 9 and extension 2782.

Please be advised that we do not guarantee benefits prior to a claim being submitted and approved. All policy provisions, exclusions and limitations will apply.