| COINSURANCE AND COPAYMENTS - CONTRACTING PROVIDERS | | | |
|---|---|---|---|
| TYPE OF SERVICE | LEVEL 1 | LEVEL 2 | LEVEL 3 |
| | YOU PAY THE FOLLOWING | | |
| Allergy Tests and Treatment | Nothing, Covered in Full | 20% of Lesser Amount | Not Covered |
| Ambulance Services | $25 Copayment | $25 Copayment, then 20% of Lesser Amount | $25 Copayment, then 30% of Lesser Amount |
| Annual Physical Exam | $10 Copayment/visit | $15 Copayment/visit, then 20% of Lesser Amount | Not Covered |
| Emergency Room - Emergency Services | Nothing, Covered in Full | Nothing, Covered in Full | Nothing, Covered in Full |
| Emergency Room - Non Emergency Services | Nothing, Covered in Full | $50 Copayment/visit, then 20% of Lesser Amount | $50 Copayment/visit, then 30% of Lesser Amount |
| Home Health Care Services | Nothing, Covered in Full | 20% of Lesser Amount | Not Covered |
| Hospice Services | Nothing, Covered in Full | 20% of Lesser Amount | Not Covered |
| Immunizations | Nothing, Covered in Full | 20% of Lesser Amount | Not Covered |
| Inpatient Mental Health Care, Drug Abuse and Alcoholism Services | Nothing, Covered in Full | 20% of Lesser Amount | Not Covered |
| Maternity and Gynecological Services | Nothing, Covered in Full | Nothing, Covered in Full | 30% of Lesser Amount |
| Office Visits | $10 Copayment/visit | $15 Copayment/visit, then 20% of Lesser Amount | $15 Copayment/visit, then 30% of Lesser Amount |
| Outpatient Laboratory Services | Nothing, Covered in Full | Nothing, Covered in Full | Nothing, Covered in Full |
| Outpatient Mental Health Care, Drug Abuse and Alcoholism Services | $10 Copayment/visit | $15 Copayment/visit, then 20% of Lesser Amount | $15 Copayment/visit, then 50% of Lesser Amount |
| Skilled Nursing Facility Services | Nothing, Covered in Full | 20% of Lesser Amount | 30% of Lesser Amount |
| Well Child Care Services | $10 Copayment/visit | $15 Copayment/visit, then 20% of Lesser Amount | Not Covered |
| All Other Covered Services | Nothing, Covered in Full | 20% of Lesser Amount | 30% of Lesser Amount |

| COINSURANCE AND COPAYMENTS - NON-CONTRACTING PROVIDERS | | | |
|---|---|---|---|
| TYPE OF SERVICE | LEVEL 1 | LEVEL 2 | LEVEL 3 |
| | YOU PAY THE FOLLOWING | | |
| Ambulance Services | $25 Copayment | $25 Copayment, then 20% of Covered Charges | $25 Copayment, then 30% of Covered Charges |
| Emergency Room - Emergency Services | Nothing, Covered in Full | Nothing, Covered in Full | Nothing, Covered in Full |
| Emergency Room - Non Emergency Services | Nothing, Covered in Full | $50 Copayment/visit, then 20% of Covered Charges | $50 Copayment/visit, then 30% of Covered Charges |
| Home Health Care Services | Nothing, Covered in Full | 20% of Covered Charges | Not Covered |
| Hospice Services | Nothing, Covered in Full | 20% of Covered Charges | Not Covered |
| Inpatient Mental Health Care, Drug Abuse and Alcoholism Services | Nothing, Covered in Full | 20% of Covered Charges | Not Covered |
| Maternity and Gynecological Services | Nothing, Covered in Full | Nothing, Covered in Full | 30% of Covered Charges |
| Outpatient Laboratory Services | Nothing, Covered in Full | Nothing, Covered in Full | Nothing, Covered in Full |
| Outpatient Mental Health Care, Drug Abuse and Alcoholism Services | $10 Copayment/visit | $15 Copayment/visit, then 20% of Covered Charge | $15 Copayment/visit, then 50% of Covered Charges |
| Skilled Nursing Facility Services | Nothing, Covered in Full | 20% of Covered Charges | 30% of Covered Charges |
| All Other Covered Services | Nothing, Covered in Full | 20% of Covered Charges | 30% of Covered Charges |

# DENTAL SCHEDULE OF BENIFITS

| | |
|---|---|
| Benefit Period: | Calendar Year |
| Benefit Period Deductible: | $50 per Covered Person |
| Maximum Benefit Payable per Covered Person per Benefit Period: | $1,000 |
| Dependent Age Limit: | The end of the month of the 23rd birthday |

It is important that you understand how MMO calculates your responsibilities under this coverage. Please consult the "HOW CLAIMS ARE PAID" section for necessary information.

| Type of Services | Maximums and Limitations |
|---|---|
| Oral Exams | Two exams per Benefit Period |
| Bitewing x-rays | Two per Benefit Period |
| Full-mouth x-rays/Panorex | One every 36 months |
| Prophylaxis | Two per Benefit Period |
| Topical Fluoride Applications | One per Benefit Period for Eligible Dependent children under age 19 |
| Space Maintainers | For Eligible Dependent children under age 19 |
| Crowns | Once every five years per tooth |
| Prosthetics (Fixed) | Once every five years per unit |
| Inlays | Once every five years per tooth |
| Onlays | Once every five years per tooth |
| Dentures (Complete and Partial) | Once every five years<br>Relining and rebasing is covered if done no less than six months after initial placement but not more than once in any 36-month period.<br>One replacement of a temporary denture if a permanent denture is installed within 12 months of the installment of the temporary denture. |

| DENTAL PAYMENT SCHEDULE | |
|---|---|
| **Type of Service** | **You Pay the Following** |
| • Oral examinations/evaluations<br>• Bitewing x-rays<br>• Prophylaxis<br>• Space maintainers<br>• Fluoride applications<br>• Emergency palliative treatments | 0% of the Usual, Customary and Reasonable Amount.<br><br>No deductible is required for these services |
| • Inlays<br>• Onlays<br>• Crowns<br>• Dentures (complete and partial)<br>• Prosthetics (fixed) | 40% of the Usual, Customary and Reasonable Amount. |
| For all other Covered Services | 20% of the Usual, Customary and Reasonable Amount. |

| ORTHODONTIC SERVICES | |
|---|---|
| Maximum Benefit Payable per Covered Person | $1,000 per Lifetime |
| Eligibility | Available for Eligible Dependent children under age 23 only |
| Deductible | No Deductible is required for Orthodontic Services |
| Your Payment Amount | 40% of the Usual, Customary and Reasonable Amount. |
| First payment for banding after the appliances are in place | Not more than 25% of the Covered Person's lifetime maximum for Orthodontic services. |

**BENEFIT VERIFICATION**
Required for any Course of Treatment exceeding $500 or involving one or more crowns.

# POS NETWORK PRESCRIPTION DRUG RIDER

This Rider amends your Certificate. Except as amended, your Certificate remains unchanged. When coverage under your Certificate ends, coverage under this Rider also ends.

## PRESCRIPTION DRUG BENEFITS

MMO will provide benefits for the Prescription Drug Negotiated Amount, minus the Prescription Drug Deductible, for Medically Necessary Prescription Drugs and refills as described below. All Prescription Drugs and refills must be prescribed by a Physician. MMO may require precertification of certain Prescription Drugs. They must be dispensed for your Outpatient use. A Prescription Drug is a medicinal substance which is required to bear the label: "Caution: Federal Law prohibits dispensing without prescription." This includes injectable medications as well as compounded medications which contain at least one such medicinal substance. MMO covers a 30-day supply or the amount of your Prescription Order, whichever is less, when provided by a Designated Pharmacy.

When Prescription Drugs are approved by the Food and Drug Administration (FDA), they will not be covered until MMO establishes criteria for Medically Necessary prescriptions. This criterion will be established within six months of the FDA approval. Some Prescription Drugs approved by the FDA may never qualify as Medically Necessary.

MMO, in its sole discretion, may limit benefits for Prescription Drugs, if the only clinical results are deemed to be lifestyle improvements and not necessary for the cure or prevention of disease, illness, or injury.

MMO will also provide benefits for the Prescription Drug Negotiated Amount, minus the Prescription Drug Deductible, for oral contraceptives and injectable insulin. Injectable insulin is covered whether or not it is prescribed. Insulin needles and syringes are Covered Services only when they are dispensed with and included on the same Prescription Order as the injectable insulin.

You will be required to pay a $5.00 Prescription Drug Deductible for each Prescription Order or refill of a Prescription Drug obtained from a Designated Pharmacy.

Generic Prescription Drugs will be dispensed unless your Physician specifies that you are to receive a Brand Name Prescription Drug. If a Generic Prescription Drug is available but you do not permit generic substitution, you must pay the difference between the cost of the Generic Prescription Drug and the Brand Name Prescription Drug at the time the Prescription Drug is dispensed to you, in addition to the Prescription Drug Deductible listed above.

Benefits are not provided for Prescription Drugs or injectable insulin if the Prescription Drug Negotiated Amount is less than the Prescription Drug Deductible. In this case, your liability is limited only to the Prescription Drug Negotiated Amount.

**Prescription Drugs and refills received from a Designated Pharmacy:**

- MMO covers the remaining liability for the Prescription Drug Negotiated Amount after you have paid the Prescription Drug Deductible. You present your identification card to the Designated Pharmacy and pay only the Prescription Drug Deductible to obtain the Covered Services. The Designated Pharmacy will then bill MMO directly and MMO will pay the Designated Pharmacy.

**Prescription Drugs and refills received from a Non-Designated Pharmacy:**

- MMO will pay 70 percent of the Average Wholesale Price of the generic equivalent of the drug. You must pay the Pharmacy the full amount of the bill for the Prescription Drug at the time of purchase. You must then file a claim form with MMO and payment will be made directly to you for 70 percent of the Average Wholesale Price of the generic equivalent of the drug, minus the Prescription Drug Deductible. You may be responsible for any amount in excess of the Prescription Drug Covered Charges.

## EXCLUSIONS

In addition to the exclusions and limitations explained in the Prescription Drug Benefits section and in your Certificate, coverage is not provided for services and supplies:

1. For birth control devices which include, but are not limited to, IUD's and diaphragms.
2. For over-the-counter medications available without a Prescription Order except insulin, insulin needles and syringes if dispensed with the insulin.
3. For more than the number of Prescription Drug refills specified by the Physician.
4. For any refill of a Prescription Drug dispensed after one year from the date of the original Prescription Order.
5. For Prescription Drugs if the Pharmacy's charge is less than or equal to the amount of the Deductible.
6. For fees for administering or injecting Prescription Drugs.

7. For a Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.
8. For drugs dispensed for cosmetic purposes: used solely for beautifying or altering one's appearance in the absence of any underlying Condition.
9. For drugs whose FDA approval indication is primarily for weight loss.
10. For any medication prescribed to induce ovulation or spermatogenesis.
11. For charges for more than a 30-day supply of a Prescription Drug.
12. Incurred or received after you stop being a Covered Person.
13. For non-covered services or services specifically excluded in the text of this Rider.

## DEFINITIONS

In addition to the definitions listed in your Certificate, the following definitions also apply to this coverage:

**Average Wholesale Price** – the current Average Wholesale Price as stated in the Drug Topics Red Book and/o the American Druggist Blue Book, including supplements, for the 100s, pints or pounds package sizes when available. If not available, the Average Wholesale Price for the next smallest package size will be used.

**Brand Name Prescription Drug** – a Prescription Drug that has been patented with the Brand Name and is produced by the original manufacturer under that Brand Name.

Designated Pharmacy - a Pharmacy which has a direct or indirect contractual obligation with MMO to provide the services of this Rider. A listing of Designated Pharmacies will be provided upon request.

**Generic Prescription Drug** – a Prescription Drug that is produced by more than one manufacturer. It is chemically the same as and usually costs less than the Brand Name Prescription Drug for which it is being substituted and will produce comparable effective clinical results.

**Pharmacy** – an Other Professional Provider which is a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

**Prescription Drug Deductible** – an amount of the Prescription Drug Negotiated Amount, usually stated in dollars, for which you are responsible before MMO will start to provide benefits for a Prescription Order or refill.

**Prescription Drug Negotiated Amount** – the amount the Provider has agreed with MMO to accept as payment in full for Covered Services.

The Prescription Drug Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees.

In certain circumstances, MMO may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the Provider instead of MMO contracting directly with the Provider itself. In these circumstances, the Prescription Drug Negotiated Amount will be based upon the agreement or arrangement MMO has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.