



**EDS**

**STANDARD**

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
<p><b>PREVENTIVE CARE</b>                      Routine Physicals, Well Baby Care,                      Immunizations (after 6<sup>th</sup> birthdate)                      Hearing Exams (routine vision is not covered)</p> <p><b>MENTAL HEALTH/CHEMICAL DEPENDENCY</b> (must be preauthorized)</p> <p><b>Inpatient Services</b>                      Hospital Services (Facility)                      Physician Services                      Calendar Year Limitations</p> <p><b>Outpatient Services</b>                       Services Performed in Physician Office (non-surgical)                      Emergency Room/Treatment Room/Facility Charges (non-emergency only)                      Professional Provider                      Visits Allowed</p> <p><b>Chemical Dependency Maximum for each Covered Individual</b></p>	<p align="center">100%</p> <p align="center">80% after cal deductible</p> <p align="center">80% after cal deductible</p> <p align="center">80% after cal deductible</p> <p align="center">80% after cal deductible</p> <p align="center">45 inpatient days /45 physician visits</p> <p align="center">80% after cal deductible</p> <p align="center">80% after cal deductible</p> <p align="center">80% after cal. yr. deductible</p> <p align="center">45 outpatient visits per cal. yr.</p>	<p align="center">100%</p> <p align="center">80% after cal deductible</p> <p align="center">70% after cal deductible</p> <p align="center">70% after cal deductible</p> <p align="center">25 inpatient days /25 physician visits</p> <p align="center"><i>Days and visits used in Network or Out-of-Network apply towards satisfying both maximums.</i></p> <p align="center">60% after cal. yr. deductible</p> <p align="center">60% after cal deductible</p> <p align="center">60% after cal deductible</p> <p align="center">25 outpatient visits per cal. yr.</p> <p align="center">Three separate series of treatments</p>
<p><b>SERIOUS MENTAL ILLNESS</b> (must be preauthorized)</p> <p><b>Inpatient Services</b>                      Hospital Services (Facility)                      Physician Services                      Calendar Year Limitations</p> <p><b>Outpatient Services</b>                       Services Performed in Physician Office (non-surgical)                      Emergency Room/Treatment Room/Facility Charges (non-emergency only)</p> <p>Professional Provider                      Number of Outpatient Visits</p>	<p align="center">80% after cal deductible</p> <p align="center">80% after cal deductible</p> <p align="center">45 inpatient days/45 physician visits</p> <p align="center">80% after cal. yr. deductible</p> <p align="center">80% after cal deductible</p> <p align="center">80% after cal deductible</p> <p align="center">45 visits per cal. yr.</p>	<p align="center">60% after cal deductible</p> <p align="center">60% after cal deductible</p> <p align="center">25 inpatient days/25 physician visits</p> <p align="center">50% after cal deductible</p> <p align="center">50% after cal deductible</p> <p align="center">50% after cal deductible</p> <p align="center">25 visits per cal. yr.</p>

**EMPLOYEE INFORMATION**

- This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.