SCHEDULE
BENEFIT PLAN FOR PPO 1000

This Schedule summarizes benefit information and the date these benefits take effect. Please read Your entire Policy to fully understand all terms, conditions, limitations and exclusions that apply.

Insurer: North Carolina Health Insurance Risk Pool, Inc.

Plan Administrator: CoreSource, Inc.
5200 77 Center Drive Suite 400
Charlotte, NC 28217-0718

Policy Effective Date: [date]

Policyholder/Covered Person: [name] Policy number: [#]

GENERAL POLICY LIMITS – These limits apply to all benefits unless stated otherwise in this Schedule. Any specific benefits not listed in this Schedule are also subject to these General Policy Limits.	
Lifetime Maximum Benefit:	$1,000,000 – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.
Annual Deductible	$1,000 - Applies to copayment and coinsurance amounts paid by You for covered medical benefits only. Drug copayments do not apply to the Annual Deductible.

	Network Provider Benefit	**Non-Network Provider Benefit**
Coinsurance:	• 80% of Covered Expenses from a Network Provider after the Deductible is satisfied - The Coinsurance applies to all Covered Expenses unless otherwise indicated.	• 50% of Covered Expenses from a Non-Network Provider after the Deductible is satisfied - The Coinsurance applies to all Covered Charges unless otherwise indicated.
Annual Out-of-Pocket Maximum:	$5,950	$7,000
INPATIENT HOSPITAL SERVICES		
Inpatient Hospital Services:	Subject to general policy limits stated above.	Subject to general policy limits stated above.
OUTPATIENT SERVICES		
Emergency Care	$150 Co-payment – Waived if admitted as inpatient Not subject to Coinsurance.	$150 Co-payment – Waived if admitted as inpatient Not subject to Coinsurance.
Outpatient Medical Services:	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Physical Medicine (Chiropractic Care):	Subject to general policy limits stated above. In addition, Maximum of 30 visits per Calendar Year.	Subject to general policy limits stated above. In addition, Maximum of 30 visits per Calendar Year.

	Network Provider Benefit	Non-Network Provider Benefit
OUTPATIENT SERVICES cont.		
Physical Medicine (Physical, Occupational and Speech Therapies):	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Urgent Care	$40 Co-payment Not subject to Coinsurance.	Subject to general policy limits stated above.
HEALTH CARE PRACTITIONER SERVICES		
Office Visits	Primary Care: $20 Co-payment Specialist: $40 Co-payment Not subject to Coinsurance.	Subject to general policy limits stated above.
MENTAL HEALTH SERVICES		
Severe Mental Illness	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Other Mental Illness	Subject to general policy limits stated above.	Subject to general policy limits stated above.
ORGAN TRANSPLANT SERVICES		
Organ Transplant Services	Subject to the general policy limits stated above when services are received from a network Center of Excellence Transplant Provider.	Lifetime maximum of $100,000 when services are received from a provider other than a network Center of Excellence Transplant Provider.
PREGNANCY SERVICES		
Maternity Benefits	Subject to general policy limits stated above.	Subject to general policy limits stated above.
PRESCRIPTION DRUG BENEFITS		
Generic Drugs	$10 Co-payment Not Subject to Coinsurance.	$10 Co-payment Not Subject to Coinsurance.
Brand Drugs	$40 Co-payment Not Subject to Deductible or Coinsurance.	$40 Co-payment Not Subject to Deductible or Coinsurance.
Specialty Drugs	The lesser of 20% or $250 Co-payment Not Subject to Deductible or Coinsurance.	The lesser of 20% or $250 Co-payment Not Subject to Deductible or Coinsurance.
Nicotine Replacement Therapy Drugs	$15 Co-payment Not Subject to Deductible or Coinsurance.	$15 Co-payment Not Subject to Deductible or Coinsurance.

	Network Provider Benefit	Non-Network Provider Benefit
PREVENTIVE CARE		
Routine Medical Care and Physical Examinations:	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.
Childhood Immunizations and Seasonal flu vaccination, H1N1 vaccination & Zostavax (Shingles) vaccination	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.
Screening Tests	Not Subject to Coinsurance.	Not Subject to Coinsurance.
Obesity Assessment	Primary Care: $20 Co-payment Specialist: $40 Co-payment Maximum of 4 visits per Calendar Year. Not Subject to Coinsurance..	Maximum of 4 visits per Calendar Year. Not Subject to Coinsurance.
SUBSTANCE ABUSE SERVICES		
Substance Abuse Services	Subject to general policy limits stated above.	Subject to general policy limits stated above.
SURGICAL SERVICES cont.		
Surgical Services	Subject to the general policy limits stated above. In addition, the services of an assistant surgeon are limited to 50% of the benefit amount payable for the services of the primary surgeon.	Subject to the general policy limits stated above. In addition, the services of an assistant surgeon are limited to 50% of the benefit amount payable for the services of the primary surgeon.
OTHER BENEFITS		
Skilled Nursing Facility	Subject to general policy limits stated above. In addition, Maximum of 60 days of inpatient care per Calendar Year.	Subject to general policy limits stated above. In addition, Maximum of 60 days of inpatient care per Calendar Year.
Jaw, Face, and Head Bone and Joint Disorders	$3,500 Lifetime Maximum for non-surgical treatments. Surgical treatments payable as described in the Surgical Services benefit.	$3,500 Lifetime Maximum for non-surgical treatments. Surgical treatments payable as described in the Surgical Services benefit.
Bariatric Surgery Services	Subject to the general policy limits stated above when services are received from a network Center of Excellence Bariatric Surgery Provider.	No Coverage