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

Plan Administrator: [CoreSource, Inc.]
[Address]

Policy Effective Date: [2/01/2011]

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

	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:	$2,000	$4,000
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 Copayment – Waived if admitted as inpatient Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	$150 Copayment – Waived if admitted as inpatient Not subject to Deductible, Coinsurance or Out-of-Pocket limits.
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.
Physical Medicine (Physical, Occupational and	Subject to general policy limits stated above.	Subject to general policy limits stated above.

	Network Provider Benefit	Non-Network Provider Benefit
Speech Therapies):	In addition, Maximum of 30 visits per Calendar Year.	In addition, Maximum of 30 visits per Calendar Year.
Urgent Care	$40 Copayment Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Subject to general policy limits stated above.
HEALTH CARE PRACTITIONER SERVICES		
Office Visits (including allergy injections, testing, and treatment)	Primary Care: $20 Copayment Specialist: $40 Copayment Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Subject to general policy limits stated above.
Health Care Practitioner Services received as part of Inpatient Hospital Services	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Health Care Practitioner Services received as part of other Covered Health Services	Subject to the same limits as the Covered Health Service for which the Health Care Practitioner Services were provided.	Subject to the same limits as the Covered Health Service for which the Health Care Practitioner Services were provided.
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. Maximum of 30 days of inpatient care per Calendar Year. Maximum of 30 Outpatient visits per Calendar Year.	Subject to general policy limits stated above. Maximum of 30 days of inpatient care per Calendar Year. Maximum of 30 Outpatient visits per Calendar Year.
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.
PRESCRIPTION DRUG BENEFITS		
Generic Drugs	$10 Copayment Not Subject to Deductible, Coinsurance or Out-of-Pocket limits.	$10 Copayment Not Subject to Deductible, Coinsurance or Out-of-Pocket limits.

	Network Provider Benefit	Non-Network Provider Benefit
Brand Drugs	$40 Copayment Not Subject to Deductible, Coinsurance or Out-of-Pocket limits.	$40 Copayment Not Subject to Deductible, Coinsurance or Out-of-Pocket limits.
Specialty Drugs	The lesser of 20% or $250 Copayment Not Subject to Deductible, Coinsurance or Out-of-Pocket limits. Annual benefit maximum of $100,000	The lesser of 20% or $250 Copayment Not Subject to Deductible, Coinsurance or Out-of-Pocket limits. Annual benefit maximum of $100,000
Nicotine Replacement Therapy Drugs	$15 Copayment Not Subject to Deductible, Coinsurance or Out-of-Pocket limits.	$15 Copayment Not Subject to Deductible, Coinsurance or Out-of-Pocket limits.
PREVENTIVE CARE		
Routine Medical Care and Physical Examinations:	$20 Copayment Specialist: $40 Copayment Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Subject to general policy limits stated above.
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 Deductible, Coinsurance or Out-of-Pocket limits.	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.
Obesity Assessment	Maximum of 4 visits per Calendar Year. Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Maximum of 4 visits per Calendar Year. Not subject to Deductible, Coinsurance or Out-of-Pocket limits.
SUBSTANCE ABUSE SERVICES		
Substance Abuse Services	Subject to general policy limits stated above. Maximum of 30 days of inpatient care per Calendar Year. Maximum of 30 Outpatient visits per Calendar Year.	Subject to general policy limits stated above. Maximum of 30 days of inpatient care per Calendar Year. Maximum of 30 Outpatient visits per Calendar Year.
SURGICAL SERVICES		
Surgical Services	Subject to the general policy limits stated above.	Subject to the general policy limits stated above.

	Network Provider Benefit	Non-Network Provider Benefit
	In addition, the services of an assistant surgeon are limited to 50% of the benefit amount payable for the services of the primary surgeon.	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