II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible -Individual -Family	 $150 $450	 $150 $450
Coinsurance After Deductible	20%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum -Individual	$5,000	$5,000
-Family	Not Covered	Not Covered
Physician Office Visits -"MyHealth Center" (Worksite Health Clinic)	$10 copay	None
-Primary Care Physician	$20 copay	30% coinsurance, after deductible
-Specialist	$20 copay	30% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year, includes blood screening, urine tests, chest x-ray, EKG & mammography)	No Charge	30% coinsurance, after deductible
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge	30% coinsurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	
Outpatient Hospital Services -Surgical	No Charge	30% coinsurance, after deductible
-Non-Surgical	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance	20% coinsurance, after deductible	30% coinsurance, after deductible
Emergency Room (Waived if admitted)	$50 copay	$50 copay plus 30% coinsurance, after deductible
Mental Health and Substance Abuse -Inpatient	No Charge	30% coinsurance, after deductible
-Outpatient • Office	$20 copay	30% coinsurance, after deductible
• Hospital	20% coinsurance, after deductible	30% coinsurance, after deductible
Home Health	20% coinsurance, after deductible	30% coinsurance, after deductible
Skilled Nursing Care	20% coinsurance, after deductible	30% coinsurance, after deductible
Durable Medical Equipment Total rental not to exceed purchase price	20% coinsurance, after deductible	30% coinsurance, after deductible
Physical, Occupational, and Speech Therapy	20% coinsurance, after deductible	30% coinsurance, after deductible
Chiropractic Benefits (Maximum of 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
For G3 Enterprises, Closure Division -**Hearing Aids** (Limited to $1,000 per year every 3 years)	No Charge	No Charge

VISION SERVICES Benefits payable during any two (2) year period with the following maximums.	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
For E&J Gallo- Modesto, Livingston, and Fresno		
Eye Exam	No Charge	No Charge
Frames/ Lenses	Any Excess after $100 per person	Any Excess after $100 per person
For G3 Enterprises, Closure Division		
Eye Exam	No Charge	No Charge
Frames/ Lenses	Any Excess after $200 per person	Any Excess after $200 per person

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic	$5 copay	Not Covered
Preferred Brand Name	20% coinsurance	Not Covered
Non-Preferred Brand Name	20% coinsurance	Not Covered
Mail Order 90-Day Supply		
Generic	$10 copay	Not Covered
Preferred Brand Name	20% coinsurance	Not Covered
Non-Preferred Brand Name	20% coinsurance	Not Covered

EMPLOYEE DEATH BENEFIT

Employee Death Benefit..... $20,000

EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Loss of:

Life	$20,000
Both Hands or Both Feet	$10,000
Entire Sight of Both Eyes	$10,000
One Hand and One Foot	$10,000
One Hand or One Foot and Entire Sight of One Eye	$10,000
One Hand or One Foot	$5,000
Entire Sight of One Eye	$5,000

Maximum payment for this benefit per occurrence is..... $10,000