II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $5,000 $10,000	 $10,000 $30,000
Coinsurance After Deductible	20%	50%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $6,600 $13,200	 $13,200 $39,600
Physician Office Visits Primary Care Physician	No Cost for the first 3 visits. After first 3 visits, 20% co-insurance, after deductible	50% co-insurance, after deductible
Specialist (Includes Cardiologists, Chiropractor, etc.)	20% co-insurance, after deductible	50% co-insurance, after deductible
Preventative Care (One exam per year for adults. Includes Physical Exams, Mammography, etc.)	No Charge	50% co-insurance, after deductible
Well Child Care/ Immunization	No Charge	50% co-insurance, after deductible
Well Women Care	No Charge	50% co-insurance, after deductible
Infertility Treatment	Not Covered	Not Covered
Pregnancy & Maternity	20% co-insurance, after deductible	50% co-insurance, after deductible
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	20% co-insurance, after deductible	50% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Room	20% co-insurance, after deductible	20% co-insurance, after deductible
Mental, Nervous and Substance Abuse Expense Inpatient	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient X-ray and Laboratory	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient Surgery	20% co-insurance, after deductible	50% co-insurance, after deductible
Skilled Nursing Facility (Limited up to 100 facility days per calendar year.)	20% co-insurance, after deductible	50% co-insurance, after deductible
Home Health Care (Limited up to 100 days per calendar year)	20% co-insurance, after deductible	50% co-insurance, after deductible
Durable Medical Equipment & Prosthetics (As medically necessary. Total rental not to exceed purchase price)	20% co-insurance, after deductible	50% co-insurance, after deductible
External Prosthetic Devices -Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenic alopecia- male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	50% coinsurance, after deductible, and any amount over $350 maximum
Physical Therapy (Includes Chiropractic)	20% co-insurance, after deductible	50% co-insurance, after deductible
Speech & Occupational Therapy	20% co-insurance, after deductible	50% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS (Mandatory Generic Substitution*)	**YOUR SHARE OF ELIGIBLE EXPENSE**	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	20% co-insurance, after deductible	Not Covered
Formulary Brand Drugs	20% co-insurance, after deductible	Not Covered
Non-Formulary Brand Drugs	20% co-insurance, after deductible	Not Covered
Mail-Order 90-Day Supply (Mandatory after 2 refills at retail)		
Generic Drugs	20% co-insurance, after deductible	Not Covered
Formulary Brand Drugs	20% co-insurance, after deductible	Not Covered
Non-Formulary Brand Drugs	20% co-insurance, after deductible	Not Covered
*If a brand name is prescribed where a generic equivalent is available, the member is responsible for the difference in cost between the brand name drug and the generic drug.		