70/50 POS PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $2,000 $4,000	 $6,000 $8,000
Co-insurance After Deductible	30%	50%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $4,000 $8,000	 $12,000 $24,000
Physician Office Visits and other eligible office expenses Specialist	$50 copay	$50% co-insurance, after deductible
Non-Specialist	$35 copay	50% co-insurance, after deductible
Preventative Care Endoscopy	Covered in Full	Covered in Full
Mammograms	Covered in Full	Covered in Full
Colonoscopy	Covered in Full	Covered in Full
Pap smear	Covered in Full	Covered in Full
Immunization, etc.	Covered in Full	Covered in Full
Routine Physical Exams	Covered in Full	Covered in Full
Laboratory and X-Ray Services	Covered in Full	50% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	30% co-insurance, after deductible	50% co-insurance, after deductible
Hospital Outpatient	30% co-insurance, after deductible	50% co-insurance, after deductible
Ambulance	30% co-insurance, after deductible	30% co-insurance, after deductible
Emergency Care (copayment waived if admitted) Hospital ER	$200 copay	$200 copay
Urgent Care Center	$50 copay	$50 copay
Mental, Alcohol and Substance Abuse Inpatient	30% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient	$50 copay	50% co-insurance, after deductible
Home Health (Nursing) Care (Limited to 60 visits)	30% co-insurance, after deductible	50% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	30% co-insurance, after deductible	50% co-insurance, after deductible
Hospice Care	Covered in Full	Covered in Full
Skilled Nursing Facility (60 days per calendar year)	30% co-insurance, after deductible	50% co-insurance, after deductible
Cardiac Rehabilitation	30% co-insurance, after deductible	50% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Physical, Occupational, Speech, Cognitive and Hearing Therapies (60 visits per calendar year)	30% co-insurance, after deductible	50% co-insurance, after deductible
Chiropractic (20 visits per calendar year)	$35 copay	50% co-insurance, after deductible
Allergy Injections	$5 copay	50% co-insurance, after deductible

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail Pharmacy 30-Day Supply		
Generic Drugs	$5 copay	Not Covered
Brand Formulary Drugs	$25 copay	Not Covered
Non-Formulary Brand Name Drugs	$50 copay	Not Covered
Specialty Drugs (requires prior authorization)	25% co-insurance	Not Covered
Mail-Order Pharmacy 90-Day Supply*		
Generic Drugs	$10 copay	Not Covered
Brand Formulary Drugs	$50 copay	Not Covered
Non-Formulary Brand Name Drugs	$100 copay	Not Covered

*Mandatory Mail Order: Following the initial fill and one refill of a covered prescription drug or therapeutic equivalent medication prescribed by one or more qualified practitioners and dispensed by one or more retail or specialty pharmacies, all subsequent refills must be obtained through a mail order pharmacy.

Some retail and specialty pharmacies participate in a program which allows you to receive a 90-day supply of a prescription or refill. Your cost is two (2) times the applicable retail and specialty pharmacy copayments as outlined above, after the prescription drug deductible is met. Self- administered injectable drugs and specialty drugs are limited to a 30-day supply from a retail or specialty pharmacy.