II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
Individual	$500	$1,000
Family	$1,000	$2,000
Coinsurance After Deductible	30%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum (Includes deductible)		
Individual	$4,000	$8,000
Family	$8,000	$16,000
Physician Office Visits		
Primary care physician	30% coinsurance, after deductible	40% coinsurance, after deductible
Specialist (includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.)	30% coinsurance, after deductible	40% coinsurance, after deductible
Preventative Care Benefits (Physical exams, lab, x-ray, immunization, vaccinations, Pap smears, mammogram, PSA tests, well child care visits, eye & ear exams)	No Charge	40% coinsurance, after deductible
Diagnostic Tests (X-rays and blood tests)	30% coinsurance, after deductible	40% coinsurance, after deductible
Ambulance (Medically necessary transportation to the nearest facility)	30% coinsurance, after deductible	30% coinsurance, after deductible
Emergency Room (Waived if admitted)	$50 copay	$50 copay
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $250	
Hospital Daily Hospital Room and Board Semi Private and other allowable expenses	30% coinsurance, after deductible	40% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Substance Use Disorder Inpatient	30% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient	30% coinsurance, after deductible	40% coinsurance, after deductible
Maternity Services Prenatal and postnatal services	30% coinsurance, after deductible	40% coinsurance, after deductible
All other hospital and physician services	30% coinsurance, after deductible	40% coinsurance, after deductible
Home Health Care	30% coinsurance, after deductible	40% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	30% coinsurance, after deductible	40% coinsurance, after deductible
External Prosthetic Devices	30% coinsurance, after deductible	40% coinsurance, after deductible
-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)	30% coinsurance, after deductible, and any amount over $350 maximum	40% coinsurance, after deductible, and any amount over $350 maximum
Cardiac Rehabilitation	30% coinsurance, after deductible	40% coinsurance, after deductible
Physical, Speech & Occupational Therapy (Each therapy requires a maximum of 24 visits per calendar year.)	30% coinsurance, after deductible	40% coinsurance, after deductible
Hospice Care	30% coinsurance, after deductible	40% coinsurance, after deductible
Skilled Nursing Facility (60 day maximum)	30% coinsurance after deductible	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Chiropractic (Limited to 40 visits per calendar year)	30% coinsurance, after deductible	40% coinsurance, after deductible
Dental Care*	30% coinsurance, after deductible	40% coinsurance, after deductible
*Accidental injury to sound natural teeth; treatment of cleft lip and palate for a dependent child under under 18; anesthesia and inpatient and outpatient hospital charges for dental care provided to a covered person who is: a child under age 5; or is severely disabled; or has a medical condition that requires hospitalization.		

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network Only	**Out-of-Network**
Retail 30-Day Supply Generic	$10 copay	Not Covered
Preferred Brand Name Drugs	20% coinsurance, up to $40 maximum	Not Covered
Non-Preferred Brand Name Drugs	35% coinsurance, up to $60 maximum	Not Covered
Specialty Drugs	20% coinsurance, up to $100 maximum	Not Covered
Mail-Order or Retail 90-Day Supply Generic	$20 copay	Not Covered
Preferred Brand Name Drugs	40% coinsurance, up to $80 maximum	Not Covered
Non-Preferred Brand Name Drugs	70% coinsurance, up to $120 maximum	Not Covered