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	$5,000	$5,000
Physician Office Visits -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
Diagnostic Tests (X-rays, blood work)	20% coinsurance, after deductible	30% coinsurance, after deductible
Imaging Services (CT and MRI scans requires prior authorization)	20% coinsurance, after deductible	30% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	Same as in-network
Emergency Room (Copay waived if admitted)	$50 copay	Same as in-network
Urgent Care	20% coinsurance, after deductible	Same as in-network

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 -Inpatient	No Charge	30% coinsurance, after deductible
-Outpatient	20% coinsurance, after deductible	30% coinsurance, after deductible
-Physician & Surgeon Fees	20% coinsurance, after deductible	30% coinsurance, after deductible
Outpatient Hospital Services -Ambulatory Surgical Facility	No Charge	30% coinsurance, after deductible
-Non Surgical	20% coinsurance, after deductible	30% coinsurance, after deductible
-Physician& Surgeon Fees	20% coinsurance, after deductible	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

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Maternity Care Services -Prenatal & postnatal	20% coinsurance, after deductible	30% coinsurance, after deductible
-Inpatient Services	No Charge	30% coinsurance, after deductible
-Delivery	20% coinsurance, after deductible	30% coinsurance, after deductible
Home Health	20% coinsurance, after deductible	30% coinsurance, after deductible
Hospice	Not Covered	Not Covered
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
External Prosthetic Devices	20% coinsurance, after deductible	30% coinsurance, after deductible
-Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgentic alopecia- male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	30% coinsurance, after deductible, and any amount over $350 maximum
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
Vision Services Benefits payable during any two (2) year period with the following maximums. -Eye Exam	No Charge	No Charge
-Frames/ Lenses	Any Excess after $100 per person	Any Excess after $100 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 $20,000
Entire Sight of Both Eyes $20,000
One Hand and One Foot..... $20,000
One Hand or One Foot and Entire Sight of One Eye $20,000
One Hand or One Foot $10,000
Entire Sight of One Eye $10,000

Maximum payment for this benefit per occurrence is $20,000