

## II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<b>Calendar Year Deductible</b> Individual Family	\$150 \$450	\$150 \$450
<b>Co-insurance After Deductible</b>	20%	40%
<b>Lifetime Maximum</b> (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
<b>Out-of-Pocket Maximum</b> Individual Family	\$1,500 \$3,000	\$1,500 \$3,000
<b>Physician Office Visits</b> Primary Doctor	20% co-insurance, after deductible	40% co-insurance, after deductible
Specialist (Includes Cardiologist, Psychiatrists, etc.)	20% co-insurance, after deductible	40% co-insurance, after deductible
<b>Preventative Care Benefits</b>	No Charge	40% coinsurance, after deductible
<b>Hospital Benefits</b> Daily Hospital Room and Board, Semi Private and other allowable expenses	20% co-insurance, after deductible	40% co-insurance, after deductible
<b>Hospital Pre-Certification Penalty</b>	25% of benefits up to a maximum of \$2,000	
<b>Ambulance</b>	20% co-insurance, after deductible	20% co-insurance, after deductible
<b>Emergency Room</b>	20% co-insurance, after deductible	20% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
<b>Mental and Substance Use Disorder</b> Inpatient	20% co-insurance, after deductible	40% co-insurance, after deductible
	20% co-insurance, after deductible	40% co-insurance, after deductible
Outpatient	20% co-insurance, after deductible	40% co-insurance, after deductible
<b>Home Health Care</b>	20% co-insurance, after deductible	40% co-insurance, after deductible
<b>Skilled Nursing Facility</b>	50% co-insurance, after deductible	50% co-insurance, after deductible
<b>Durable Medical Equipment</b> (Total rental not to exceed purchase price)	20% co-insurance, after deductible	40% co-insurance, after deductible
<b>Hospice Care</b>	20% coinsurance, after deductible	40% coinsurance, after deductible
<b>Physical, Occupational and Speech Therapy</b>	20% co-insurance, after deductible	40% co-insurance, after deductible
<b>Chiropractic</b> (Limited to 12 visits per calendar year)	20% co-insurance, after deductible	40% co-insurance, after deductible

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network (No Deductibles)	Out-of-Network
<b>Mandatory Generic Substitution Applies</b>		
<b>Retail 30-Day Supply</b>		
Generic Drugs	\$5 copay	Not Covered
Preferred Brand Name Drugs	\$30 copay**	Not Covered
Non-Preferred Brand Name Drugs	\$30 copay**	Not Covered

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network (No Deductibles)	Out-of-Network
<b>Mail-Order 90-Day Supply</b>		
Generic Drugs	\$10 copay	Not Covered
Preferred Brand Name Drugs	\$60 copay**	Not Covered
Non-Preferred Brand Name Drugs	\$60 copay**	Not Covered
**If a brand name drug 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.		