II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Annual Deductible Individual Family	 $250 $450	 $350 $550
Co-insurance After Deductible	10%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $2,000 $4,000	 $3,000 $5,000
Physician Services -Non Specialist	$20 copay	30% co-insurance, after deductible
-Specialist	$25 copay	30% co-insurance, after deductible
-Emergency Room Visits	10% co-insurance, after deductible	30% co-insurance, after deductible
-Inpatient Services	10% co-insurance, after deductible	30% co-insurance, after deductible
-Outpatient Services (Includes Surgery and Diagnostic Lab/ X-Rays)	10% co-insurance, after deductible	30% co-insurance, after deductible
Preventative Care (Calendar Year Deductible Waived) -Routine Mammogram	 No Charge	 30% co-insurance, after deductible
-Routine Cancer Screening	No Charge	30% co-insurance, after deductible
Allergy Immunizations	10% co-insurance, after deductible	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Laboratory and Radiology Services	10% co-insurance, after deductible	30% co-insurance, after deductible
Ambulance	20% co-insurance, after deductible	30% co-insurance, after deductible
Emergency Room Visit	$50 copay	30% co-insurance, after deductible
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)	10% co-insurance, after deductible	30% co-insurance, after deductible
Organ Transplants Limited to Heart, Liver (Until Age 18), Kidney and Bone Marrow	No Charge	Not Covered
Outpatient Surgical Services and Non-Surgical Services	10% co-insurance, after deductible	30% co-insurance, after deductible
Mental and Nervous Expense -Inpatient	10% co-insurance, after deductible	Not Covered
-Outpatient	$25 copay	Not Covered
-Group Therapy	$25 copay	Not Covered
Alcohol and Substance Abuse -Inpatient	10% co-insurance, after deductible	Not Covered
-Outpatient	$25 copay	Not Covered
-Group Therapy	$25 copay	Not Covered
-Residential Rehabilitation Services • Facility	20% co-insurance, after deductible	Not Covered
• Doctor	No Charge	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% co-insurance, after deductible	20% co-insurance, after deductible
External Prosthetic Devices	20% co-insurance, after deductible	20% co-insurance, after deductible
-Wigs, toupees or hairpieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgentic alopecia-male pattern baldness)	20% co-insurance, after deductible, up to a maximum of $350	20% co-insurance, after deductible, up to a maximum of $350
Cardiac Rehabilitation	20% co-insurance, after deductible	30% co-insurance, after deductible
Home Health (Nursing) Care (Maximum of 40 visits per calendar year)	20% co-insurance, after deductible	20% co-insurance, after deductible
Skilled Nursing Facility	20% co-insurance, after deductible	20% co-insurance, after deductible
Private Duty Nursing	20% co-insurance, after deductible	20% co-insurance, after deductible
Hospice -Inpatient	$150 per day	$150 per day
-Outpatient	$50 per day	$50 per day
Physical, Speech, and Hearing Therapy (Maximum of 20 visits per calendar year)	20% co-insurance, after deductible	30% co-insurance, after deductible
Chiropractic Benefits (Maximum of 12 visits per calendar year)	$20 copay	30% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail (30-Day Supply)		
-Generic	$10 copay	Not Covered
-Brand Formulary	$20 copay	Not Covered
-Non-Formulary	$30 copay	Not Covered
Mail Order (90-Day Supply) (Mandatory mail order purchase of maintenance drugs after the first fill at retail)		
-Generic	$20 copay	Not Covered
-Brand Formulary	$40 copay	Not Covered
-Non-Formulary	$60 copay	Not Covered
Specialty Drugs		
-Generic	$10 copay	Not Covered
-Brand Formulary	$20 copay	Not Covered
-Non-Formulary	$30 copay	Not Covered

Death Benefit for Retired Employee $10,000

CONTINUATION OF COVERAGE FOR RETIREES

Eligibility – Retirement on/or after age..... 50
Period of Coverage .....Up to Age 65 or Medicare Eligibility