II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $300 $600	 $10,000 $20,000
Coinsurance After Deductible	20%	50%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum (includes deductibles, copays and coinsurance) Individual Family	 $5,000 $10,000	 $30,000 $60,000
Physician Office Visits and Other In-office Services -Primary Care Physician	$30 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% coinsurance, after deductible
-Specialist	$50 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% coinsurance, after deductible
Preventative Care Benefits (Routine exams, x-rays/ tests, immunization, well baby care and mammograms)	No Charge	50% coinsurance, after deductible
Diagnostic Tests (X-rays and blood work)	20% coinsurance, after deductible	50% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Urgent Care Center Services -General Physician	$30 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% coinsurance, after deductible
-Specialist	$50 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (copay waived if admitted)	20% coinsurance, after deductible	20% coinsurance, after deductible
Imaging Services (PET, CT and MRI scans requires prior authorization)	20% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient	20% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient	20% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Hospital and Physician Services	20% coinsurance, after deductible	50% coinsurance, after deductible
- Ambulatory Surgery Center and Physician Services	No Charge	50% coinsurance, after deductible
Maternity Care Services -Prenatal Care	No Charge	No Charge
-Postnatal Care	20% coinsurance, after deductible	50% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
-All other hospital and physician services	20% coinsurance, after deductible	50% coinsurance, after deductible
Mental and Substance Abuse Services -Inpatient	20% coinsurance, after deductible	50% coinsurance, after deductible
-Outpatient	$30 copay	50% coinsurance, after deductible
• Other covered services	20% coinsurance No deductible	50% coinsurance, after deductible
Hospice	20% coinsurance, after deductible	Not Covered
Home Health Care	20% coinsurance, after deductible	Not Covered
Skilled Nursing Facility (Limited up to 120 days per confinement)	20% coinsurance, after deductible	50% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	50% coinsurance, after deductible
External Prosthetic Devices -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% coinsurance, after deductible, up to a maximum of $350	50% coinsurance, after deductible, up to a maximum of $350
Physical, Occupational and Speech Therapy	20% coinsurance, after deductible	50% coinsurance, after deductible
Chiropractic Services	20% coinsurance, after deductible	50% coinsurance, after deductible
Eyewear for children under the age of 19 (1 pair standard frame and lenses or contact lenses)	20% coinsurance, after deductible	Not Covered

PRESCRIPTION DRUG PLAN (Mandatory Generic Substitution Applies*)	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$10 copay	Not Covered
Brand Formulary Drugs	$50 copay	Not Covered
Brand Non-Formulary Drugs	$150 copay	Not Covered
Specialty Drugs	20% coinsurance to a maximum of $300	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$30 copay	Not Covered
Brand Formulary Drugs	$150 copay	Not Covered
Brand Non-Formulary Drugs	$450 copay	Not Covered

SHORT TERM DISABILITY BENEFIT

Benefits payable the 1st day of an accident, 7th day of sickness, for 25 weeks

Weeks 1 – 25 ..... 60% of weekly salary up to a maximum of $1,500

EMPLOYEE DEATH BENEFIT

Employee Death Benefit..... $10,000

EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Loss of:

Life $10,000
Both Hands or Both Feet..... $10,000
Entire Sight of Both Eyes $10,000
One Hand and One Foot..... $10,000
One Hand or One Foot and Entire Sight of One Eye $10,000
One Hand or One Foot $5,000
Entire Sight of One Eye $5,000

Maximum payment for this benefit per occurrence is..... $10,000