II. SCHEDULE OF BENEFITS

CORE PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $1,000 $2,000	 $2,000 $4,000
Co-insurance After Deductible	25%	50%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum Individual	$6,000	Unlimited
Family	$12,000	Unlimited
Physician Office Visits Primary Physician	$35 copay	50% co-insurance, after deductible
Specialist	$70 copay	50% co-insurance, after deductible
Preventive Care	No Charge	50% co-insurance, No Deductible
Allergy Testing and Injections	25% co-insurance, after deductible	50% co-insurance, after deductible
Infertility Counseling and Testing	25% co-insurance, after deductible	50% co-insurance, after deductible
Radiology (X-ray) and Laboratory Services Diagnostic	25% co-insurance, after deductible	50% co-insurance, after deductible
Routine Preventative Radiology and Laboratory Testing	No Charge	50% co-insurance, after deductible
Ambulance	25% co-insurance, after deductible	25% co-insurance, after deductible

CORE PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Emergency Care Hospital ER (copay waived if admitted)	$750 copay	$750 copay
Urgent Care Center	$35 copay	$35 copay
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient Services	25% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient Services	25% co-insurance, after deductible	50% co-insurance, after deductible
Mental and Substance Abuse Inpatient Hospital	25% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient -Hospital	25% co-insurance, after deductible	50% co-insurance, after deductible
-Office	$70 copay	50% co-insurance, after deductible
Accidental Dental Treatment	25% co-insurance, after deductible	50% co-insurance, after deductible
Home Health Care	25% co-insurance, after deductible	50% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	25% co-insurance, after deductible	50% co-insurance, after deductible
Respiratory Therapy	25% co-insurance, after deductible	50% co-insurance, after deductible
Physical Medicine Limited to 20 visits per calendar year	$70 copay	50% co-insurance, after deductible

CORE PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSES	
	In-Network	**Out-of-Network**
Speech and Occupational Therapy Limited to 20 visits per calendar year.	$70 copay	50% co-insurance, after deductible
Other Therapies	25% co-insurance, after deductible	50% co-insurance, after deductible
Chiropractic Services Limited to 20 visits per calendar year.	$70 copay	50% co-insurance, after deductible
Skilled Nursing Facility Limited 100 days per calendar year.	25% co-insurance, after deductible	50% co-insurance, after deductible
Private Duty Nursing	25% co-insurance, after deductible	50% co-insurance, after deductible
Hospice	25% co-insurance, after deductible	50% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$15 copay	Not Covered
Brand Name Drugs	$40 copay	Not Covered
Non – Preferred Brand Name Drugs	$60 copay	Not Covered
Specialty Prescription Drugs	$100 copay	Not Covered
Mail Order 90-Day Supply		
Generic Drugs	$37.50 copay	Not Covered
Brand Name Drugs	$100 copay	Not Covered
Non – Preferred Brand Name Drugs	$150 copay	Not Covered
Specialty Prescription Drugs	$250 copay	Not Covered