II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $2,700 $5,400	 $2,700 $5,400
Coinsurance After Deductible	No Charge	No Charge
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum (Includes deductible) Individual Family	 $2,700 $5,400	 $2,700 $5,400
Physician Office Visits Non-Specialist	 No charge after deductible	 No charge after deductible
Specialist	No charge after deductible	No charge after deductible
Preventive Services/ Immunizations	No Charge	Not Covered
Ambulance	No charge after deductible	No charge after deductible
Outpatient Emergency Services	No charge after deductible	No charge after deductible
Organ Transplants	No charge after deductible	Not Covered
Hospital Pre-Certification Penalty	$250	

SUMMARY OF BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient	No charge after deductible	No charge after deductible
Outpatient	No charge after deductible	No charge after deductible
Dental Anesthesia and outpatient hospital charges for children under age 5, severely disabled, or has a medical condition requiring hospitalization or general anesthesia for dental treatment	No charge after deductible	No charge after deductible
Maternity Care Services Inpatient	No Charge	No charge after deductible
Outpatient	No Charge	No charge after deductible
Mental Health Inpatient	No charge after deductible	No charge after deductible
Outpatient	No charge after deductible	No charge after deductible
Substance Abuse Inpatient	No charge after deductible	No charge after deductible
Outpatient	No charge after deductible	No charge after deductible
Skilled Nursing Facility (60 days calendar year maximum)	No charge after deductible	No charge after deductible
Home Health Care (100 visit maximum per calendar year)	No charge after deductible	No charge after deductible
Hospice Care ($5,000 lifetime maximum)	No charge after deductible	No charge after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Durable Medical Equipment (Total rental not to exceed purchase price. Includes: corrective lenses for aphakia)	No charge after deductible	No charge after deductible
External Prosthetic Devices -Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment of androgentic alopecia- male pattern baldness)	No charge after deductible Limited up to $350 maximum	No charge after deductible Limited up to $350 maximum
Physical, Occupational, Speech Therapy	No charge after deductible	No charge after deductible
Chiropractic	No charge after deductible	No charge after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network **(After the deductible)**	**Out-of-Network** **(After the deductible)**
Retail 30-Day Supply		
Generic	No Charge	No Charge
Preferred Brand Formulary	No Charge	No Charge
Non-Preferred Brand	No Charge	No Charge
Retail 90-Day Supply ***(Maintenance Drugs used for long term use/ chronic condition)***		
Generic	No Charge	Not Covered
Preferred Brand Formulary	No Charge	Not Covered
Non-Preferred Brand	No Charge	Not Covered

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF THE ELIGIBLE EXPENSE	
	In-Network **(After the deductible)**	**Out-of-Network** **(After the deductible)**
Mail Order 90-Day Supply		
Generic	No Charge	No Charge
Brand Formulary	No Charge	No Charge
Non-Preferred Brand	No Charge	No Charge
Specialty Drugs	No Charge	No Charge