II. SCHEDULE OF BENEFITS

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Employee + 1 Family	 $500 $1,000 $1,500	 $1,500 $3,000 $4,500
Coinsurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum (includes deductibles and copays) Individual Employee + 1 Family	 $2,000 $4,000 $6,000	 $4,500 $9,000 $13,500
Physician Office Visits and Other In-office Services Primary Care Physician	$20 copay	40% coinsurance, after deductible
Specialist	$30 copay	40% coinsurance, after deductible
Preventative Care Benefits (routine exams, x-rays/tests immunizations, well baby care and mammograms)	No Charge	40% coinsurance, after deductible
Diagnostic Tests (X-rays and blood work)	20% coinsurance, after deductible	40% coinsurance, after deductible
Imaging Services (CT and MRI scans requires prior authorization)	20% coinsurance, after deductible	40% coinsurance, after deductible
Ambulance	No Charge	No Charge
Emergency Room (Copay waived if admitted)	$100 copay	$100 copay

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Urgent Care Services	$100 copay	$100 copay
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	20% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient Surgery Center (Includes ambulatory surgery centers)	20% coinsurance, after deductible	40% coinsurance, after deductible
Maternity Care Services -Office Visits	$20 copay for 1st Visit	40% coinsurance, after deductible
-Professional & Facility	20% coinsurance, after deductible	40% coinsurance, after deductible
Mental and Substance Use Disorder -Residential	No Charge Deductible Applies	40% coinsurance, after deductible
-Inpatient	No Charge Deductible Applies	40% coinsurance, after deductible
-Outpatient (Partial Hospitalization and Intensive Outpatient Services)	No Charge Deductible Applies	40% coinsurance, after deductible
• Office visits	$30 copay	40% coinsurance, after deductible
ABA Therapy (Limited to 240 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Home Health Care (30 visits for out-of-network providers)	20% coinsurance, after deductible	40% coinsurance, after deductible
Hospice Care Services	No Charge	No Charge
Skilled Nursing Facility (Limited to 100 days per calendar year.)	20% coinsurance, after deductible	40% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	40% coinsurance, after deductible

PPO PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
External Prosthetic Devices	20% coinsurance, after deductible	40% coinsurance, after deductible
-Wigs, toupee or hair pieces (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, and any amount over $350 maximum	40% coinsurance, after deductible, and any amount over $350 maximum
Physical, Occupational and Speech Therapy (Limited up to 60 combined visits per calendar year)	$20 copay	40% coinsurance, after deductible
Chiropractic Care Services (Maximum of 12 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Acupuncture Services (Limited to 12 visits per calendar year)	No Charge	40% coinsurance, after deductible
Hearing Aids (Limited to children under the age 12 years of age- 1 pair every 24 months)	20% coinsurance, after deductible	40% coinsurance, after deductible
Temporomandibular Joint Disorder (TMJ)	20% coinsurance, after deductible	40% coinsurance, after deductible
Dental Anesthesia and Hospital for Children Under 5 Years Old or Disabled	20% coinsurance, after deductible	40% coinsurance, after deductible
Removal of Impacted Teeth	20% coinsurance, after deductible	40% coinsurance, after deductible

PPO PLAN

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$15 copay	Not Covered
Preferred Brand Name Drugs	20% coinsurance; $30 min/ $60 max	Not Covered
Non-Preferred Brand Name Drugs	30% coinsurance; $50 min/ $100 max	Not Covered
Specialty Drugs	30% coinsurance; $50 min/ $100 max	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$30 copay	Not Covered
Preferred Brand Name Drugs	20% coinsurance; $60 min/ $120 max	Not Covered
Non-Preferred Brand Name Drugs	30% coinsurance; $100 min/ $200 max	Not Covered