II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $250 $500	 $250 $500
Coinsurance After Deductible	20%	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	 $6,850 $13,700	 $13,700 $41,000
Physician Office Visits and other eligible office expenses Primary Doctor	20% coinsurance, after deductible	30% coinsurance, after deductible
Specialist (Includes Cardiologist, Psychiatrists, etc.)	20% coinsurance, after deductible	30% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, chest x-ray, EKG, & mammography)	No Charge	30% coinsurance, after deductible
Laboratory Services	20% coinsurance, after deductible	30% coinsurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge	30% coinsurance, after deductible
Hospital Pre-Certification Penalty	50% of benefits up to a maximum of $5,000	
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Copay waived if admitted)	$50 copay, plus 20% coinsurance	$50 copay, plus 20% coinsurance

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Substance Use Disorder Inpatient	No Charge	30% coinsurance, after deductible
Outpatient	20% coinsurance, after deductible	30% coinsurance, after deductible
Home Health Care	20% coinsurance, after deductible	30% coinsurance, after deductible
Skilled Nursing Facility	20% coinsurance, after deductible	30% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	30% coinsurance, after deductible
Physical, Occupational and Speech Therapy	20% coinsurance, after deductible	30% coinsurance, after deductible
Chiropractic (Up to 12 visits per calendar year)	20% coinsurance, after deductible	30% coinsurance, after deductible
Vision Benefits (Benefits payable during any two year period) -Eye Exam	No Charge	No Charge
-Frames/ Lenses	All Except $100	All Except $100

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mandatory for maintenance medication after 1 prescription at retail		
Retail 30-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	10% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered

EMPLOYEE DEATH BENEFIT

Employee Death Benefit... $5,000

EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

For Loss of:

Life $5,000
Both Hands or Both Feet... $5,000
Entire Sight of Both Eyes $5,000
One Hand and One Foot.. $5,000
One Hand or One Foot and Entire Sight of One Eye $5,000
One Hand or One Foot $2,500
Entire Sight of One Eye $2,500

Maximum payment for this benefit per occurrence is... $5,000