II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 None None	 $500 $1000
Co-insurance After Deductible	10%	30%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum Individual Family	 $500 $1,000	 $1,000 $2,000
Physician Office Visits	10% co-insurance	30% co-insurance, after deductible
Preventative Care Benefits (Calendar Year Deductible Waived) Routine Cancer Screening	No Charge	30% co-insurance, after deductible
Preventative Child Care	No Charge	30% co-insurance, after deductible
Ambulance	10% co-insurance	30% co-insurance, after deductible
Emergency Room	10% co-insurance	30% co-insurance, after deductible
Hospital Pre-Certification Penalty	$400	
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	10% co-insurance	30% co-insurance, after deductible
Birth Center/ Related Physician Expense	No Charge	30% co-insurance, after deductible
Second Surgical Opinion	No Charge	30% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Pre-Operative Testing	No Charge	30% co-insurance, after deductible
Outpatient Surgical Expense	No Charge	30% co-insurance, after deductible
Mental Health		
Inpatient	10% co-insurance	30% co-insurance, after deductible
Outpatient	10% co-insurance	30% co-insurance, after deductible
Alcohol & Substance Abuse		
Inpatient	10% co-insurance	30% co-insurance, after deductible
Outpatient	10% co-insurance	30% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	10% co-insurance	30% co-insurance, after deductible
External Prosthetic Devices -Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenic alopecia- male pattern baldness)	10% coinsurance, after deductible, and any amount over $350 maximum	30% coinsurance, after deductible, and any amount over $350 maximum
Hospice Care (Limited to 30 days)	10% co-insurance	30% co-insurance, after deductible
Skilled Nursing Facility Care (120 allowable days of confinement per calendar year)	10% co-insurance	30% co-insurance, after deductible
Home Health (Nursing) Care (Limited up to 120 days per calendar year)	10% co-insurance	30% co-insurance, after deductible
Chiropractic Benefits (Limited to 20 visits per calendar year)	10% co-insurance	30% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail (30-Day Supply)		
Generic Drugs	$10 copay	Not Covered
Brand Name Drugs	$10 copay**	Not Covered
Mail Order (90-Day Supply)		
Generic Drugs	$10 copay	Not Covered
Brand Name Drugs	$10 copay**	Not Covered
**If a generic medication is available and a brand name medication is dispensed, the member will be responsible for the $10 copay plus the portion of the cost of the brand name medication, which exceeds the cost of the equivalent generic medication.		