II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	HMO PLAN	
	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible	None	Not Covered
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum - Medical Individual Family	 $1,500 $3,000	 Not Covered Not Covered
- Specialty Pharmacy Drugs (Includes infertility, excludes deductible) Individual Family	 $1,500 $4,500	 Not Covered Not Covered
Calendar Year Maximum Benefits Outpatient Prescription Drugs	 No Charge	 Not Covered
Specialty Pharmacy Drugs (Includes infertility)	$750,000 per member	Not Covered
Physician Office Visits Primary Care Physician	 $25 copay	 Not Covered
Specialist	$25 copay	Not Covered
Preventative Care - Routine Physical Exams	 $25 copay	 Not Covered
- Immunizations	No Charge	Not Covered
- Diagnostic Tests and X-rays	No Charge	Not covered
- MRI's and CAT Scans	No Charge	Not Covered
- Well Care	No Charge	Not Covered

SUMMARY OF BENEFITS	HMO PLAN	
	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Allergy Testing and Treatment	No Charge	Not Covered
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient	$40 copay per day up to a maximum of $400 copay per admission	Not Covered
Outpatient	No Charge	Not Covered
Ambulance	No Charge	Not Covered
Emergency Room (Copay waived if admitted)	$150 copay	Not Covered
Infertility Services Doctor's Office	$25 copay	Not Covered
Hospital	$40 copay per day up to a maximum of $400 copay per admission	Not Covered
Maternity Care - Routine Prenatal Care	$50 copay per pregnancy	Not Covered
- Hospital Care Mother	$40 copay per day up to a maximum of $400 copay per admission	Not Covered
- New Born Care • First 5 Days	No Charge	Not Covered
• On the 6th day	$40 copay per day up to a maximum of $400 copay per admission	Not Covered

SUMMARY OF BENEFITS	HMO PLAN	
	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Second Opinion: A consultation with a board of certified surgeon is covered after receiving a recommendation for surgery. If the second opinion does not confirm the primary surgeon's opinion, a third opinion is covered.	$25 copay	Not Covered
Human Organ Transplant	No Charge (after office visit copay or hospital care copay)	Not Covered
Outpatient Surgery/ Procedures	No Charge	Not Covered
Mental and Nervous Expense Inpatient	$30 copay	Not Covered
Outpatient	$25 copay	Not Covered
Alcohol & Substance Abuse Inpatient	$30 copay	Not Covered
Outpatient	$25 copay	Not Covered
Durable Medical Equipment, Orthopedic, Appliances, and Orthotics (Includes: rental of oxygen equipment, hospital beds, and wheelchairs. Total rental not to exceed purchase price)	20% co-insurance	Not Covered
Prostheses (Copays and coinsurance for the services do not apply to your Medical Calendar Year Out-of-Pocket Maximum) Maximum of 80 visits per calendar year	20% co-insurance	Not Covered

SUMMARY OF BENEFITS	HMO PLAN	
	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Rehabilitation Services (Includes: Speech, Physical and Occupational therapy) Inpatient (Includes Skilled Nursing) Maximum of 120 days per calendar year	No Charge	Not Covered
Outpatient (Includes Home Care) Maximum of 60 visits per calendar year per condition	$25 copay	Not Covered
Outpatient Speech Therapy for Pervasive Developmental Disorder (Maximum of 80 visits. Includes Home Setting)	$25 copay	Not Covered
Hospice Care	No Charge	Not Covered
Home Health Services	No Charge	Not Covered
Chiropractic Benefits	$30 copay	Not Covered
Temporomandibular Joint Syndrome	Not Covered	Not Covered
Dental Services	Not Covered	Not Covered
Vision Care (Copays and coinsurance for the services do not apply to your Medical Calendar Year Out-of-Pocket Maximum)	$25 copay	Not Covered

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail (30-Day Supply)		
Generic	$10	Not Covered
Preferred Brand Formulary	$20	Not Covered
Non Preferred Brand	$40	Not Covered
Mail Order (90-Day Supply)		
Generic	$20	Not Covered
Preferred Brand Formulary	$40	Not Covered
Non Preferred Brand	$80	Not Covered
Prescription Contraceptive Devices/ Injectables* (In Doctor's Office)	20% co-insurance	Not Covered
Infertility Outpatient Prescription Drugs*		
Generic	$10	Not Covered
Preferred Brand Formulary	$20	Not Covered
Non Preferred Brand	$40	Not Covered
*Copays and Co-insurance for the services do not apply to your Medical Calendar Year Out-of-Pocket Maximum.		