II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible	$500	Not Covered
Coinsurance After Deductible	No Charge	Not Covered
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Physician Office Visits and Other Eligible Expenses in Office	$50 copay	Not Covered
Preventative Care Includes: Well Child Care, Routine Physical exams, Routine Mammogram, Routine colonoscopy, pap smear, and prostate exam and test.	No Charge	No Charge
Laboratory Services	No Charge, after deductible	Not Covered
Ambulance	No Charge, after deductible	No Charge, after deductible
Emergency Care Hospital ER	$75 copay	$75 copay
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses	No Charge, after deductible	Not Covered
Hospital Pre- Certification Penalty for Mental & Nervous and Alcohol & Substance Abuse Confinements	$500	
Mental and Nervous Expense Inpatient	No Charge, after deductible	Not Covered
Outpatient	$50 copay	Not Covered
Partial Hospitalization	No Charge, after deductible	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Alcohol & Substance Abuse Inpatient (Maximum 28 days)	No Charge, after deductible	Not Covered
Outpatient (As medically necessary)	No Charge, after deductible	Not Covered
Partial Hospitalization	No Charge, after deductible	Not Covered
Chiropractic (36 visits per calendar year)	$50 copay	Not Covered
Home Health/ Hospice Care	No Charge, after deductible	Not Covered
Inpatient Hospice Pre- Certification Penalty	$500	
Durable Medical Equipment (Total rental not to exceed purchase price.) Breast Prosthesis (2 per year)	No Charge, after deductible	Not Covered
Mastectomy Bras (3 per year)	No Charge, after deductible	Not Covered
Scalp Hair Prosthesis (1 per year)	Any cost over $350	
Cardiac Rehabilitation	No Charge, after deductible	Not Covered
Physical, Occupational, and Speech Therapy (Limited to 60 visits per calendar year each)	$50 copay	Not Covered
Eye/Ear Exams	$50 copay	Not Covered
Infertility (Limited to 6 cycles for IVF-ET, ZIFT, GIFT and NORIF/NORIVF)	No Charge, after deductible	Not Covered
Nutritional Counseling	No Charge, after deductible	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mastectomy Reconstruction	No Charge, after deductible	Not Covered
Early Intervention Services	No Charge, after deductible	Not Covered
Organ/Tissue Transplants	No Charge, after deductible	Not Covered
Oral Surgery (Limited to extraction of erupted teeth before radiation therapy for malignant disease and surgical removal of bone impacted teeth)	No Charge, after deductible	Not Covered
Temporomandibular Joint Disorder (TMJ) (Exams and X-Rays)	No Charge, after deductible	Not Covered
Enteral Formula and Modified Low Protein Food Products	No Charge, after deductible	Not Covered
Hearing Aids (Limited to one hearing aid each time a prescription changes, for members 18 years of age or younger)	No Charge, after deductible	Not Covered
Skilled Nursing Facility	No Charge, after deductible	Not Covered
Physical Rehabilitation Facility	No Charge, after deductible	Not Covered

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30- Day Supply		
Generic Drugs	$10 copay	Not Covered
Preferred Brand Name Drugs	$30 copay	Not Covered
Non-Preferred Brand Name Drugs	$50 copay	Not Covered
Retail 60- Day Supply		
Generic Drugs	$20 copay	Not Covered
Preferred Brand Name Drugs	$60 copay	Not Covered
Non-Preferred Brand Name Drugs	$100 copay	Not Covered
Retail and Mail Order 90- Day Supply		
Generic Drugs	$30 copay	Not Covered
Preferred Brand Name Drugs	$90 copay	Not Covered
Non-Preferred Brand Name Drugs	$150 copay	Not Covered