II. SCHEDULE OF BENEFITS

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $500 $1,000	 $1,000 $2,000
Co-insurance After Deductible	20%	50%
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	 $4,800 $9,600	 $7,500 $15,000
Physician Office Visits -Well Care (Includes: well-child care, administration of injections/immunizations, periodic routine physical exams, annual eye exam, hearing screening test, family planning services, diagnostic lab tests and X-rays) • Non Specialist	No Charge	No Charge
• Specialist	No Charge	No Charge
-Illness (Includes: Surgical procedures, administration of injections/ immunizations, changes and removal of cast, dressing or sutures, diagnostic lab tests and X -rays) • Non Specialist	$20 copay	50% co-insurance, after deductible
• Specialist	$30 copay	50% co-insurance, after deductible
Physician Services at Home	$30 copay	50% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Ambulance	20% co-insurance, after deductible	20% co-insurance, after deductible
Emergency Room (Waived if admitted)	$50 copay	$50 copay
Hospital or Surgical Facility Benefits Semi-private room and board, intensive care, coronary care and hospital special services	20% co-insurance, after deductible	50% co-insurance, after deductible
Hospital Pre-Certification Penalty	$500	
Inpatient Services Physicians' and surgeons' services including consultations and prescribed private duty nursing.	No Charge	50% co-insurance, after deductible
Outpatient Services Anesthesia services, radiation therapy and endoscopic procedures	20% co-insurance, after deductible	50% co-insurance, after deductible
Physicians and Surgeons Services	No Charge	50% co-insurance, after deductible
Laboratory & Radiology Services	No Charge	50% co-insurance, after deductible
Infertility Limited to 5 cycles for IVF-ET, ZIFT,GIFT, and NORIF/NORIVF, including artificial insemination Doctor's office	$30 copay	Not Covered
Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible
Maternity Care Prenatal and postpartum care & all hospital services for mother and child	20% co-insurance No Deductible	50% co-insurance, after deductible
With prior approval from the Fund, covered individuals, who are more than 3 months pregnant on the date their coverage begins, under the Fund, may continue with their current provider and receive the In-Network Benefit payment level		

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Nervous Expense Inpatient	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient • Doctor's office	$30 copay	50% co-insurance, after deductible
• Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible
Alcohol and Substance Abuse Inpatient	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient • Doctor's office	$30 copay	50% co-insurance, after deductible
• Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible
Human Organ Transplants	No Charge after deductible	50% co-insurance, after deductible
Artificial Replacement of a Natural Body Part Initial	No Charge	50% co-insurance, after deductible
Replacement	20% co-insurance, after deductible	50% co-insurance, after deductible
Oral Surgery The removal of 7 or more permanent teeth, excision of bony impacted teeth, reduction of fractures, gingivectomies of more than one quadrant, and excisions of lesions (Refer to Shaw's Dental Plan SPD for information on other covered services.		
Doctor's Office	$30 copay	50% co-insurance, after deductible
Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Cardiac Rehabilitation	20% co-insurance, after deductible	50% co-insurance, after deductible
Skilled Nursing Facility and Inpatient Rehabilitation Includes room and board, special services and physician services. Limited up to 100 days per person per calendar year for each benefit.	20% co-insurance, after deductible	50% co-insurance, after deductible
Hospice Care	No Charge after deductible	50% co-insurance, after deductible
Home Health Care (Intermittent skilled nursing care, Home care services, and prescribed private duty nursing)	No Charge	50% co-insurance, after deductible
Home Care Services	No Charge	50% co-insurance, after deductible
Prescribed Private Duty Nursing	No Charge	50% co-insurance, after deductible
Intermittent Skilled Nursing Care at Home	No Charge	50% co-insurance, after deductible
Durable Medical Equipment (Includes rental of oxygen equipment, hospital bed, wheelchairs. Total rental not to exceed purchase price)	20% co-insurance, after deductible	50% 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)	20% coinsurance, after deductible, and any amount over $350 maximum	50% coinsurance, after deductible, and any amount over $350 maximum
Ostomy Supplies	No Charge after deductible	50% co-insurance, after deductible
Dialysis Doctor's Office	$30 copay	50% co-insurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible
Chiropractic & Physical Therapy Services Up to 60 consecutive days combined benefit per calendar year, per condition Doctor's office	$30 copay	50% co-insurance, after deductible
Facility	20% co-insurance, after deductible	50% co-insurance, after deductible
Short-Term Speech and Occupational Therapies Up 60 consecutive days per calendar year for each condition Doctor's office	$30 copay	50% co-insurance, after deductible
Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible
Nutritional Counseling Doctor's office	No Charge	30% co-insurance, after deductible
Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible
Formulas for Certain Conditions	No Charge, after deductible	50% co-insurance, after deductible
Early Intervention Services	No Charge, after deductible	50% co-insurance, after deductible
Lead Screening for Children Doctor's office	No Charge	50% co-insurance, after deductible
Hospital	No Charge	50% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Osco Pharmacy		
Generic	$5 copay	$15 copay
Preferred Brand Name	$24 copay	$34 copay
Non-Preferred Brand Name	$34 copay	$44 copay
Non Osco Pharmacy		
Generic	$10 copay	$15 copay
Preferred Brand Name	$29 copay	$34 copay
Non-Preferred Brand Name	$39 copay	$44 copay
90- Day Supply		
Osco Pharmacy- Retail		
Generic	$10 copay	Not Covered
Preferred Brand Name	$48 copay	Not Covered
Non-Preferred Brand Name	$102 copay	Not Covered
Non-Osco Pharmacy– Mail Order		
Generic	$20 copay	Not Covered
Preferred Brand Name	$58 copay	Not Covered
Non-Preferred Brand Name	$117 copay	Not Covered