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	None	None
Physician Office Visits	20% coinsurance, after deductible	30% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening, urine tests, chest x-ray, EKG, & mammography)	No Charge	30% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	30% coinsurance, after deductible
Emergency Room (copay waived if admitted)	$50 copay, plus 20% coinsurance	$50 copay, plus 30% coinsurance
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	
Outpatient Hospital Services Surgical	No Charge	30% coinsurance, after deductible
Non-Surgical	20% coinsurance, after deductible	30% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Mental and Nervous Expense 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 Care	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 (2) year period with the following maximums. Eye Exam	No Charge	No Charge
Frames/ Lenses	Any Excess after $100 per person	Any Excess after $100 per person

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Retail 30-Day Supply		
Generic Drugs	10% coinsurance	Not Covered
Preferred Brand Name Drugs	20% coinsurance	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	10% coinsurance	Not Covered
Preferred Brand Name Drugs	20% coinsurance	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance	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