II. SCHEDULE OF BENEFITS

BENEFITS ARE PAYABLE FOR IN-NETWORK EXPENSES FOR EMPLOYEES ONLY

SUMMARY OF BENEFITS	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, medical expenses and prescription benefits)	Unlimited	
Out-of-Pocket Maximum (Per person per calendar year)	$1,000	Not Covered
Physician Office Visits and other eligible expenses Specialist (Includes Cardiologists, Psychologists, Dermatologists, Podiatrists, etc.)	$20 copay	Not Covered
Non Specialist	$10 copay	Not Covered
Preventive Care	No Charge	Not Covered
Diagnostic Testing in Doctor's Office	No Charge	Not Covered
MRI, MRA & Pet Scans	$100 copay	Not Covered
Maternity Diagnostic Ultrasounds and Fetal Monitors Facility	10% coinsurance	Not Covered
Professional	$20 copay	Not Covered
Ambulance	No Charge	Not Covered
Emergency Care (Hospital ER)	10% coinsurance	Not Covered

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Benefits: Daily Hospital Room and Board, Semi-Private and other allowable expenses	10% coinsurance	Not Covered
Maternity	$200 copay	Not Covered
Outpatient Hospital Expenses (Includes: MRI, MRA and Pet Scan)	10% coinsurance	Not Covered
Professional Charges for Inpatient	No Charge	Not Covered
Mental Health and Substance Abuse Services		
Inpatient Facility	10% coinsurance	Not Covered
Inpatient Professional	No Charge	Not Covered
Partial Hospitalization Facility	10% coinsurance	Not Covered
Partial Hospitalization Professional	$20 copay	Not Covered
Outpatient Professional	$20 copay	Not Covered
Inpatient Surgical		
Facility	10% coinsurance	Not Covered
Professional	No Charge	Not Covered
Outpatient Surgical		
Facility	10% coinsurance	Not Covered
Professional	$20 copay	Not Covered
Organ and Tissue Transplants, Transfusions	When covered human organ or tissue transplant is provided from a living donor to a member, both the recipient and the donor may receive benefits.	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Durable Medical Equipment (Total rental not to exceed purchase price.)	No Charge	Not Covered
Prosthetics	10% coinsurance	Not Covered
External Prosthetic Devices -Wigs, toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenetic alopecia- male pattern baldness)	10% coinsurance, after deductible, and any amount over $350 maximum	Not Covered
Dialysis	$40 per month copay	Not Covered
Skilled Nursing Facility (100 days per condition)	10% coinsurance	Not Covered
Hospice Care	No Charge	Not Covered
Home Health Care and Infusion	No Charge	Not Covered
Chiropractic (Limited to 30 visits per year)	$20 copay	Not Covered
Vision Exam (One per calendar year)	$20 copay	Not Covered
Outpatient Therapies Facility	10% coinsurance	Not Covered
Professional	$20 copay	Not Covered
Services included are: Chemotherapy, Infusion, Radiation Therapy, Cardiac Rehabilitation and Respiratory Therapy. Physical and Occupational Therapy are combined for 30 visits per calendar year. Speech Therapy is limited to 30 visits per calendar year.		

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Wellness		
Facility	10% coinsurance	Not Covered
Professional	No Charge	Not Covered
Routine Wellness: Primary Care Physicians, Gynecologist exams, pap tests, mammographies (one baseline mammography screening for patients ages 35-39; and an annual mammography screening for patients age 40 and older), PSA tests, prostate exams, immunizations, lab, x-ray and colorectal cancer screenings.		

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$5 copay	Not Covered
Preferred Brand Name Drugs	$20 copay	Not Covered
Non-Preferred Brand Name Drugs	$35 copay	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	$10 copay	Not Covered
Preferred Brand Name Drugs	$40 copay	Not Covered
Non-Preferred Brand Name Drugs	$70 copay	Not Covered

SHORT TERM DISABILITY

Benefits payable the 1st day of an accident, 8th day of a sickness, for 26 weeks

Weeks 1-26 .... $250

EMPLOYEE DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

Active Employee $25,000

Accidental Death and Dismemberment Benefits

For loss of:

For loss of	Benefit
Life	$25,000
Both Hands or Both Feet	$25,000
Entire Sight of Both Eyes	$25,000
One Hand and One Foot	$25,000
One Hand or One Foot and Entire Sight of One Eye	$25,000
One Hand or One Foot	$12,500
Entire Sight of One Eye	$12,500

Maximum benefit per occurrence is.. $25,000