## II. SCHEDULE OF BENEFITS

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Calendar Year Deductible** | | |
| Individual | $3,000 | $3,000 |
| Family | $6,000 | $6,000 |
| **Coinsurance After Deductible** | 20% | 30% |
| **Lifetime Maximum** (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits) | Unlimited | |
| **Out-of-Pocket Maximum** (Includes deductible) | | |
| Individual | $4,000 | $4,000 |
| Family | $8,000 | $8,000 |
| **Physician Office Visits** | | |
| Primary care physician | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| Specialist (includes cardiologists, psychiatrists, dermatologists, podiatrists, etc.) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Preventative Care Benefits** (Physical exams, lab, x-ray, immunization, vaccinations, Pap smears, mammogram, PSA tests, well child care visits, eye & ear exams) | No Charge | Not covered |
| **Diagnostic Tests** (X-rays and blood tests) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Ambulance** (Medically necessary transportation to the nearest facility) | 20% coinsurance, after deductible | 20% coinsurance, after deductible |
| **Emergency Room** | 20% coinsurance, after deductible | 20% coinsurance after deductible |
| **Hospital Pre-Certification Penalty** | 50% of benefits up to a maximum of $250 | |
| **Hospital** Daily Hospital Room and Board Semi Private and other allowable expenses | 20% coinsurance, after deductible | 30% coinsurance, after deductible |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Mental and Substance Use Disorder**<br>Inpatient | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| Outpatient | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Maternity Services**<br>Prenatal and postnatal services | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| All other hospital and physician services | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Home Health Care**<br>(Limited to 40 visits per calendar year) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Durable Medical Equipment**<br>(Total rental not to exceed purchase price.) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **External Prosthetic Devices** | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| -Wigs, toupees or hair pieces<br>(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 | 30% coinsurance, after deductible, and any amount over $350 maximum |
| **Cardiac Rehabilitation** | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Physical, Speech & Occupational Therapy**<br>(Combined of 50 visits per calendar year.) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Hospice Care** | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Skilled Nursing Facility**<br>(120 day maximum) | 20% coinsurance, after deductible | Not Covered |

| SUMMARY OF BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Chiropractic**<br>(Limited to 40 visits per calendar year) | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| **Dental Care*** | 20% coinsurance, after deductible | 30% coinsurance, after deductible |
| *Accidental injury to sound natural teeth; treatment of cleft lip and palate for a dependent child under 18; anesthesia and inpatient and outpatient hospital charges for dental care provided to a covered person who is: a child under age 5; or is severely disabled; or has a medical condition that requires hospitalization. | | |

| PRESCRIPTION DRUG BENEFITS | YOUR SHARE OF ELIGIBLE EXPENSE | |
|---|---|---|
| | **In-Network Only** | **Out-of-Network** |
| **Retail 30-Day Supply**<br>Generic | $10 copay | Not covered |
| Preferred Brand Name Drugs | 20% coinsurance, up to $40 maximum | Not covered |
| Non-Preferred Brand Name Drugs | 35% coinsurance, up to $60 maximum | Not covered |
| Specialty Drugs | 20% coinsurance, up to $100 maximum | Not covered |
| **Mail-Order or Retail 90-Day Supply**<br>Generic | $20 copay | Not covered |
| Preferred Brand Name Drugs | 40% coinsurance, up to $80 maximum | Not covered |
| Non-Preferred Brand Name Drugs | 70% coinsurance, up to $120 maximum | Not covered |