BILL WILLIAMS TIRE CENTER SCHEDULE OF MEDICAL BENEFITS

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, "Medical Covered Expenses", "Claim Review and Audit Program", and "Exclusions and Limitations." You may find the "Definitions" section helpful in understanding some of the italicized terms used throughout this *summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect benefits, such as "Cost Containment Provisions," and it is strongly recommended that you read the entire *summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact the *claims administrator* or the *Plan Administrator* for assistance.

Lifetime Maximum Benefits

Any separate lifetime maximums are included in, and are not in addition to, the Lifetime Maximum for All Benefits, shown below. The following lifetime maximums apply to each *covered person*:

Lifetime Maximum Benefits for:	
Annual Maximum for All Benefits	unlimited

The *plan year* for this *Plan* is the calendar year from January 1 through December 31 each year.

Plan Year Maximum Benefits

Plan year maximum benefits will accumulate toward any applicable lifetime maximum limits.

***Plan Year* Maximum Benefits per *Covered Person* for:**	
Skilled Nursing Facility Care	90 days
Chiropractic Care	$500
Routine Foot Care – Non-surgical	$2,000
Routine Mammogram Screening	1exam
Second Surgical Opinion – Per Surgery	$100
Organ Donor Expenses – Per Transplant	$10,000

Deductible

	PPO Network Providers* and Non-*PPO Network Providers
Plan Year Deductible • Individual • *Family Unit*	 $3,000 $9,000

Percentage Payable and Out-of-Pocket Expense Limits

	Hospital* Facilities *Ambulatory Surgery Centers* Dialysis Facilities and *PPO Network Providers	**Non-*PPO Network Providers***
Percentage Payable (unless otherwise stated)	60%	50%
Out-of Pocket Expense Limit • Individual • *Family Unit*	 $6,850 $13,700	 $10,000 $20,000
Certain types of expenses are not eligible to accumulate toward the *out-of-pocket expense limit*. Please refer to the section, "Your Costs", for additional information.		

Section I
Applicable to the following facilities:
- ***Hospitals***
- ***Ambulatory Surgery Centers***
- **Dialysis Facilities**

Payment Levels and Limits – Hospital, Ambulatory Surgery Centers and Dialysis Facilities
This section of the Schedule of Medical Benefits applies only to covered expenses which are rendered by *hospital* facilities, *ambulatory surgery centers* and dialysis clinics and facilities. The benefits shown apply to all such covered, licensed *providers* of service without regard to participation in a *PPO*.

Percentage Payable For:	***Hospital Inpatient* Services**	Limits:
Medical/Surgical Room & Board & Ancillary	60% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	
Skilled Nursing Facility, Convalescent Care and Extended Care Facility	60% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	Limited to 90 days per *plan year* maximum
Mental or Nervous Disorder Inpatient	60% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	
Mental or Nervous Disorder Facility Outpatient	60% of *allowable claim limits* • *deductible* applies	
Substance Abuse Care *Inpatient*	60% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	
Substance Abuse Care Facility Outpatient	60% of *allowable claim limits* • *deductible* applies	
***Hospital* Emergency Room Services**		
Hospital Emergency Room - *Accident** or *Illness*	60% of *allowable claim limits* • *deductible* applies	
*Supplemental Accident Benefit	100% of *allowable claim limits* to $300 per *accident* – thereafter subject to *deductible* and reimbursed at 60% of *allowable claim limits*	
Hospital* Outpatient *Diagnostic Services		
Diagnostic X-ray and Laboratory	60% of *allowable claim limits* • *deductible* applies	
Routine Mammogram – Covered Persons Over Age 35	100 % of *allowable claim limits* • *deductible* waived	Limited to one exam per *plan year* maximum
Pre-Admission Testing	100% of *allowable claim limits* • *deductible* waived	
All Other Covered *Hospital* Services and Supplies		
All Other Covered Expenses	60% of *allowable claim limits* • *deductible* applies	
***Ambulatory Surgery Centers* Covered Services and Supplies**		
All Covered Expenses	60% of *allowable claim limits* • *deductible* applies	

Physician's Office and Outpatient Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
All *Covered Expenses*, Including: • Office Visit • *Surgery* • Lab or X-rays • Allergy Care • Injections • Other Covered Services	100 % up to $300 after a copayment of $40 per visit, *deductible* waived *Covered expenses* thereafter are subject to the *deductible* and reimbursed at 60% of the *PPO* rate	50% of *usual, customary and reasonable* fees • *deductible* applies	
Wellness Benefits as described by ACA	100%	50% of *usual, customary and reasonable* fees *deductible* applies	
Mental or Nervous Disorder Office Visit and Outpatient	100 % up to $300 after a copayment of $40 per visit, *deductible* waived *Covered expenses* thereafter are subject to the *deductible* and reimbursed at 60% of the *PPO* rate	50% of *usual, customary and reasonable* fees • *deductible* applies	
Substance Abuse Office Visit and Outpatient	100 % up to $300 after a copayment of $40 per visit, *deductible* waived *Covered expenses* thereafter are subject to the *deductible* and reimbursed at 60% of the *PPO* rate	50% of *usual, customary and reasonable* fees • *deductible* applies	

Chiropractic Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Chiropractic Care and Therapies	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	Limited to $500 per *plan year* maximum benefit

Other Covered Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Therapy • Physical • Occupational • Speech • IV and Infusion • Cardiac Rehabilitation	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Chemotherapy and Radiation Therapy	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Durable Medical Equipment	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	

Section II
Applicable to all other providers of service:

Payment Levels and Limits – Physician and Other Provider Expenses
The following tables apply to all *providers* of service other than *hospital* facilities, *ambulatory surgery centers* and dialysis facilities. Benefits are available, as shown, for reimbursement of *covered expenses* based upon the *provider's* participation in the *PPO network.*

***Physician* In-Hospital Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Physician Medical Hospital Visit	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Physician – Mental or Nervous Disorder Hospital Visit	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Physician – Substance Abuse Hospital Visit	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	

Second Surgical Opinion Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Office Visit For Second Surgical Opinion	100% of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable* fees • *deductible* waived	

Surgical Services – *Inpatient* and Outpatient/Office			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Anesthesia	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Assistant Surgeon	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	Limited to 25% of surgical fee allowance
Obstetrical	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Surgeon – Office	$40 copayment, then 100% of *PPO* rate to $300 – *deductible* waived *Covered expenses* thereafter are subject to the *deductible* and reimbursed at 60% of the *PPO* rate	50% of *usual, customary and reasonable* fees • *deductible* applies	
Surgeon – All Other	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	

Other Covered Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Home Health Services	100% of *PPO* rate • *deductible* applies	100% of *usual, customary and reasonable* fees • *deductible* applies	
Hospice	100% of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable* fees • *deductible* waived	
Routine Non-Surgical Foot Care	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	Limited to $2,000 per *plan year* maximum benefit
Diagnostic Laboratory and X-Ray, and Pathologist Fees and Radiologist Fees	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Pre-Admission Testing	100% of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable* fees • *deductible* waived	
Routine Mammogram – *Covered Persons* Over Age 35	100 % of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable* fees • *deductible* waived	Limited to one exam per *plan year* maximum
Ambulance — Air or Ground Transportation	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Blood and Administration	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Oxygen and Administration	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Prosthetic Devices	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Lenses Following Cataract Surgery	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	
Supplemental Accident Benefit	100% of *PPO* rate to $300 per accident – thereafter subject to *deductible* and reimbursed at 60% of *PPO* rate	100% of *usual, customary and reasonable* fees to $300 per accident – thereafter subject to *deductible* and reimbursed at 50% of *usual, customary and reasonable* fees	
Prescription Drugs Mail Order	100% of *usual, customary and reasonable* fees, *deductible* waived, subject to copayments as follows: • $10 per prescription or refill for generic drugs, or • $30 plus 30% of the cost of brand name drugs per prescription or refill • $25 per prescription or refill for generic drugs, or • $75 plus 30% of the cost of brand name drugs per prescription or refill		Limited to 30-day supply per purchase Limited to 90-day Supply per purchase

Other Covered Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
All Other *Covered Expenses*	60% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable* fees • *deductible* applies	

Dental Summary of Benefits

Type A – Preventive	100%
Type B – Basic	80%
Type C – Major	50%
Orthodonita	50%
Deductible ▪ **Individual** ▪ **Family**	 $50 $150
Calendar Year Maximum *(applies to A,B,C services)*	$1,500
Orthodontia 19 yrs-under	50%
Orthodontia Lifetime Maximum	$1,500
The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by ISOL (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.	

TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 1 time in 6 months
▪ Prophylaxis: Cleanings	▪ 1 time in 6 months
▪ Sealants	▪ 1 per molar in 60 months for a child under age 14
▪ Space Maintainers	▪ 1 per lifetime for a child under age 14
▪ Fluoride	▪ 1 time in 12 months for a dependent child under age 14
▪ Full Mouth X-Rays	▪ Once in 60 months
▪ Bitewing X-Rays	▪ For a child under 14: 1 time in 12 months ▪ Adult: 1 time in 12 months
▪ Periapical X-Rays	
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Consultations	▪ 1 in 12 months
▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Periodontal Maintenance	▪ 4 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 4)
▪ Prefabricated Stainless Steel & Resin Crowns	▪ 1 per tooth in 10 calendar years
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months
▪ Occlusal Adjustments	▪ 1 in 12 months
▪ Labs & Other Tests	

▪ Emergency Palliative Treatment	
▪ Other X-Rays	
▪ Resin Composite Fillings(includes coverage for composite fillings on molars)	
▪ Oral Surgery: Simple Extractions	
▪ General Services	
TYPE C ***Benefits are payable after 12 months continuous coverage***	
▪ Cone Beam Imaging	▪ 1 in 60 months
▪ Root Canal	▪ 1 in 24 months
▪ Periodontal Surgery	▪ 1 per quadrant in any 60 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 60 month period
▪ Crown Buildups / Post Core	▪ 1 per tooth in 10 calendar years
▪ Dentures	▪ 1 in 10 calendar years
▪ Immediate Temporary Dentures – Complete / Partial	▪ 1 replacement in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 60 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 10 calendar years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 10 calendar years
▪ Implant Services	▪ 1 per tooth position in 10 calendar years
▪ Implant Repairs	▪ 1 per tooth in 10 calendar years
▪ Implant Supported Prosthetic	▪ 1 per tooth in 10 calendar years
▪ Tissue Conditioning	▪ 1 in 60 months
▪ General Anesthesia	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ Occlusal Guards / Bruxism Appliances	
Orthodontics ***Benefits are payable after 12 months continuous coverage***	
▪ Orthodontic Diagnostics	
* ▪ Orthodontic Treatment	Age 19 and under

Exclusions
▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.

BWT

Vision Summary of Benefits

Eye Examination – 12 months	Up to $50
Frames – 24 months	Up to $130
Lenses – 12 months **Single Vision** **Bifocal** **Trifocal** **Lenticular**	 Up to $60 Up to $85 Up to $115 Up to $170
Contact Lenses – 12 months	Up to $175
Deductible	None

The insurance does not pay for visual analysis or vision aids that are not medically necessary

Vision coverage also excludes and no charges are paid for any part of a charge that exceeds prevailing charges.

- Sunglasses (prescribed or not)
- Duplication or replacement of vision aid broken, lost or stolen
- More than one complete visual analysis in any period of 12 consecutive months
- More than two lenses (one pair) in any period of 12 consecutive months
- One set of frames any period of 24 consecutive months
- Medical or Surgical treatment of the eyes
- Treatment or service that would be provided at no charge in the absence of insurance