SCHEDULE OF BENEFITS

The following ***Schedule of Benefits*** is designed as a quick reference. For complete provisions of the Plan's benefits, refer to the following sections: ***Health Care Management, Medical Expense Benefit, Medical Expense Benefit Exclusions*** and ***Plan Exclusions.*** Limitations are combined maximums for services and supplies rendered by Preferred and Non-Preferred Providers.

MEDICAL MAXIMUM BENEFITS:

Maximum Benefit per Covered Person while covered by this Plan for:

Medical Expenses	$ 2,000,000
Chemical Dependency and Substance Abuse	$ 25,000
Temporomandibular Joint Syndrome	$ 750

Maximum Benefit per Occurrence for Transplant Benefits:

Aggregate Maximum for Travel and Accommodations	$ 10,000

Maximum Benefit per Covered Person per Calendar Year for:

Mental and Nervous Disorders	
Inpatient Services	10 days per Calendar Year
Outpatient Services	20 visits per Calendar Year
Chemical Dependency Inpatient &/or Outpatient Hospital Combined	$ 10,000
Inpatient Services	$ 10,000
Chemical Dependency Outpatient Services*	$ 2,000
* (Included in the Inpatient and/or Outpatient limit of $10,000)	
Extended Care/Skilled Nursing Facility	90 days per Calendar Year
Wellness Benefits	$ 300
Chiropractic/Spinal Manipulation	26 visits per Calendar Year

Calendar Year Deductible:	**PPO Provider**	**Non-PPO Provider**
Individual Deductible	$ 200	$ 500
Family Deductible	$ 600	$ 1,500

Out-of-Pocket Expense Limit Per Calendar Year: (includes Deductible)	**PPO Provider**	**Non-PPO Provider**
PPO/Individual	$ 1,200	$ 2,500
PPO/Family	$ 2,400	$ 5,000

Additional Deductibles/Coinsurance Penalty:

Inpatient Admission **NOT** Pre-Authorized	$ 300
*Inpatient admissions include Hospitals, Rehabilitation Centers, Treatment Centers, and Extended Care or Skilled Nursing Facilities.	
Outpatient Surgery **NOT** Pre-Authorized	$ 300
Failure to utilize Approved/Designated Transplant Facility	20% reduction in Coinsurance

The Plan pays the percentage listed on the following pages for Covered Expenses incurred by a Covered Person during a Calendar Year after the Individual or Family Deductible has been satisfied and until the Individual or Family Out-of-Pocket Expense Limit has been reached. Thereafter, the Plan pays 100% of incurred Covered Expenses for the remainder of the Calendar Year, or until the Maximum Benefit has been reached. Refer to the section entitled ***Medical Expense Benefit, Out-of-Pocket Expense Limit*** for a listing of charges not applicable to the 100% Coinsurance.

BENEFIT DESCRIPTION	PPO PROVIDER	NON-PPO PROVIDER
INPATIENT HOSPITAL	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission.**		
OUTPATIENT HOSPITAL/SURGERY: Hospital or Ambulatory Surgical Centers	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Outpatient surgical services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved surgical procedure.**		
AMBULANCE	90% Subject to Deductible	50% Subject to Deductible
EMERGENCY ROOM SERVICES: Facility and Physician charges	90% after $50 Co-payment* Deductible Waived	50% Subject to Deductible
***The Co-payment is waived if Covered Person is admitted to the Hospital; coverage reverts to Hospital Inpatient as noted above.**		
URGENT CARE	100% after $25 Co-payment, Deductible Waived	50% Subject to Deductible
PRE-ADMISSION TESTING	90% Deductible Waived	50% Subject to Deductible
SECOND SURGICAL OPINION	100% after $10 Co-payment, Deductible Waived	50% Subject to Deductible
PHYSICIANS' SERVICES: Office visits, In-office surgical procedures, specialist consultation, in-office x-ray and lab, allergy testing	100% after $10 Co-payment, Deductible Waived	50% Subject to Deductible
PHYSICIAN SERVICES: Inpatient or Outpatient surgery, Inpatient Hospital visits	90% Deductible Waived	50% Subject to Deductible
WELLNESS CARE:	100% to Maximum Benefit of $300, Deductible Waived*	Denied
***Maximum Benefit of $300 per Covered Person per Calendar Year.**		
MAMMOGRAMS	100% Deductible Waived	50% Subject to Deductible
OUTPATIENT DIAGNOSTIC X-RAYS	90% Deductible Waived	50% Subject to Deductible
OUTPATIENT LABORATORY	90% Deductible Waived	50% Subject to Deductible
DURABLE MEDICAL EQUIPMENT	90% Subject to Deductible	50% Subject to Deductible
EXTENDED CARE/SKILLED NURSING FACILITY	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission. Maximum Benefit of 90 days per Calendar Year.**		
HOME HEALTH CARE	90% Subject to Deductible	50% Subject to Deductible
HOSPICE CARE	90% Subject to Deductible	50% Subject to Deductible
***Maximum Benefit per family unit for family bereavement counseling is $300.**		
PODIATRY SERVICES	90% Subject to Deductible	50% Subject to Deductible
MENTAL AND NERVOUS DISORDERS Inpatient Services	90% Subject to Deductible*	50% Subject to Deductible*

BENEFIT DESCRIPTION	PPO PROVIDER	NON-PPO PROVIDER
***Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission Inpatient services subject to maximum 10 days per calendar year.**		
Outpatient Services	90% Subject to Deductible*	50% Subject to Deductible*
***Outpatient services subject to Maximum Benefit of 20 visits per Calendar Year.**		
CHEMICAL DEPENDENCY		
Inpatient Services	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission Lifetime Maximum Benefit of $25,000 and $10,000 per Calendar Year per Covered Person for Inpatient and/or Outpatient services combined.**		
Outpatient Services	90% Subject to Deductible*	50% Subject to Deductible*
***Maximum Benefit of $2,000 per Calendar Year per Covered Person for Outpatient services (included in the Inpatient and/or Outpatient limit of $10,000 combined).**		
REHABILITATIVE SERVICES: Speech Therapy, Physical Therapy, Occupational Therapy	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required for Inpatient services. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission**		
THERAPEUTIC SERVICES: Radiology, Dialysis, Chemotherapy	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission**		
CHIROPRACTIC CARE/SPINAL MANIPULATION	100% after $10 Co-payment, Deductible Waived*	50% Subject to Deductible*
*** Maximum Benefit of 26 visits per Calendar Year.**		
TEMPOROMANDIBULAR JOINT SYNDROME	90% Subject to Deductible*	50% Subject to Deductible*
***Maximum Lifetime Benefit of $750.**		
ALL OTHER COVERED EXPENSES	90% Subject to Deductible	50% Subject to Deductible

PRESCRIPTION DRUG PROGRAM

		Participating Pharmacy
Prescription Drug Card		
	Generic	$ 7 Co-payment / 30-Day Supply
	Name Brand	$ 14 Co-payment / 30-Day Supply
Mail Order Program		
	Generic	$14 Co-payment / 100-day supply.
	Brand Name	$28 Co-payment / 100-day supply.

DENTAL EXPENSE BENEFIT SCHEDULE:

The following are Covered Dental Services. Refer to the section entitled ***Dental Expense Benefit***, for details regarding the services covered, exclusions, limitations and other provisions of the Dental Benefit.

SERVICES

	PPO	Non-PPO
Class I – Basic Services*	100%	80%
***Subject to Maximum Annual Benefit per Covered Person; Deductible Waived**		
Class II – Restorative Services*	80%	60%
***Subject to Calendar Year Deductible and Maximum Annual Benefit per Covered Person**		
Class III – Major Services*	80%	60%
***Subject to Calendar Year Deductible and Maximum Annual Benefit per Covered Person**		
Class IV – Orthodontia*	50%	50%
***Subject to the separate and additional Orthodontia Deductible and Orthodontia Maximum Lifetime Benefit**		
Classes II, III and IV		
Calendar Year Deductible Per Covered Person (Maximum 3 per Family)	$ 50	$ 50
Classes I, II, and III		
Maximum Annual Benefit Per Covered Person	$ 1,000	$ 1,000
Class IV - Orthodontia		
Orthodontia Maximum Lifetime Benefit Per Covered Person	$ 2,000	$ 2,000
Covered Persons Limitation: Benefits payable for Dependent children under age nineteen (19) only.		