SCHEDULE OF BENEFITS

Maximum Benefit Amount	$5,000,000
PPO Network	IHG - Interplan Health Group (formerly AHP)
In-Network Benefits	
Calendar Year Deductible	
In-Network Individual Deductible Amount	$400
In-Network Family Deductible Amount	$800
In-Network Coinsurance Percentage	90%
Office Visit Copay Amount	$15
Emergency Room Access Fee (in addition to deductible)	$50
In-Network Maximum Coinsurance Share Per Calendar Year	
Per Individual	$500
Per Family	$1,000
Out of Network Benefits	
Calendar Year Deductible	
Out of Network Individual Deductible Amount	$800
Out of Network Family Deductible Amount	$1,600
Out of Network Coinsurance Percentage	70%
Non-preferred Provider Hospital Inpatient Access Fee (in addition to deductible)	$250
Reasonable & Cutomary Percentile Level	60th
Out of Network Maximum Coinsurance Share Per Calendar Year	
Per Individual	$1,500
Per Family	$3,000
Home Health Care	
Maximum Number of Visits per Calendar Year	40

Skilled Nursing Facility	
Maximum Number of Days per Calendar Year	31
Transplant Benefit	
Designated Transplant Facility	100%
Non-designated Transplant Facility	
90% of first $100,000 after the Deductible	
100% thereafter for the remainder of the Calendar Year	
Prescription Drug Card Benefit	Included
Calendar Year Prescription Deductible	$50
Prescription Stop Loss Amount	$3,550
Retail Prescription Copay Amount Before Stop Loss Is Reached	
Generic Prescription Copay Amount	$15 or 20% of the cost of the drug, whichever is greater
Preferred Brand Prescription Copay Amount	$25 or 25% of the cost of the drug, whichever is greater
Non-preferred Brand Prescription Copay Amount	$40 or 40% of the cost of the drug, whichever is greater
Mail Order Prescription Copay Amount Before Stop Loss Is Reached	
Generic Mail Order Prescription Copay Amount	$20
Preferred Brand Mail Order Prescription Copay Amount	$50
Non-preferred Brand Mail Order Prescription Copay Amount	$80
Prescription Copay Amounts After Stop Loss Amount Has Been Reached	
Generic Prescription Copay Amount	$15
Preferred Brand Prescription Copay Amount	$25
Non-preferred Brand Prescription Copay Amount	$40

Optional Benefits

Wellness Benefit for Preventive Health Care (Preferred Provider Only)	Included
Copay Amount for Preventive Health Care Exam	$15
Maximum Wellness Benefit	$250
Hospital Benefits for Dental Surgery	Included
Pregnancy Like Any Illness	Included
Infertility & In Vitro Fertilization Benefit	Included
Supplemental Accident Benefit 100% to $400	Included
Mental Health Parity Benefit	Included

Federal Continuation of Health Insurance Coverage After Termination Included

Precertification

To precertify a hospital stay, please call 1-800-245-3005.

NOTE: Most policies require preauthorization for durable medical equipment and home health. For preauthorization of these types of service please call the case management department at 800-371-9622 dial option 9 and extension 2782.

Please be advised that we do not guarantee benefits prior to a claim being submitted and approved. All policy provisions, exclusions and limitations will apply.