# SCHEDULE OF BENEFITS

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|---|---|
| Maximum Benefit Amount | $5,000,000 |
| PPO Network | WPPN |
| 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 |