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| <b>Plan Name:</b>   | PPO 1500          |                       |
| <b>Annual Deductible, Out-of Pocket and Lifetime Benefit Maximums</b> | <b>In Network</b> | <b>Out of Network</b> |
| Annual Deductible (Single/Family)                                     | \$1500/\$4,500    | \$3,000/\$9,000       |
| Out-of-pocket Annual Maximum (Single/Family) Includes deductible      | \$3,000/\$9,000   | No Limit              |
| Plan Coinsurance (After Annual Deductible)                            | 80%               | 60%                   |
| Lifetime Transplant Benefit Maximum                                   | \$1,000,000       |                       |
| Lifetime Non-Transplant Benefit Maximum                               | \$2,000,000       |                       |

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| <b>Benefit Limits</b>  |                   |
| Allergy Testing Lifetime Limit   | Once Per Lifetime |
| DME & Prosthetics Combined Annual Maximum  | \$2,000           |
| Home Health Services Annual Limit  | 30 Visits         |
| Infertility Diagnosis Lifetime Maximum   | \$1,000           |
| Inpatient Mental Health and Substance Abuse Combined Annual Limit                  | 20 Days           |
| Outpatient Rehabilitative Services Annual Limit                                    | 30 Visits         |
| Preventative Health Services Annual Limit  | 1 Visit           |
| Routine Gynecological Exam Annual Limit  | 1 Exam            |
| Skilled Nursing Facility & Inpatient Rehabilitation Services Combined Annual Limit | 30 Days           |
| TMJ Benefit Annual Maximum   | \$500             |

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| <b>Co-payments/Co-Insurance Sharing</b>  |                  |                  |
| Allergy Care   | *\$30/Visit      | 60% Co-insurance |
| Ambulance (Life Threatening Emergency Only)  | 80% Co-insurance | 60% Co-insurance |
| CAT Scan and MRI   | 80% Co-insurance | 60% Co-insurance |
| DME & Prosthetics  | 80% Co-insurance | 60% Co-insurance |
| Emergency Room (Co-payment Waived if Admitted)   | *\$250           | *\$250           |
| Home Health Visits   | 80% Co-insurance | 60% Co-insurance |
| Inpatient Hospital Care  | 80% Co-insurance | 60% Co-insurance |
| Inpatient Lab, X-Ray, and other Diagnostic Services                                      | 80% Co-insurance | 60% Co-insurance |
| Inpatient Mental Health  | *\$100/Day       | 60% Co-insurance |
| Inpatient Rehabilitation   | *\$500/Admission | 60% Co-insurance |
| Inpatient Substance Abuse  | *\$100/Day       | 60% Co-insurance |
| Maternity Care- Obstetric Office Visits & Delivery (available only with Family Coverage) | 80% Co-insurance | 60% Co-insurance |
| Newborn Care in the Hospital   | 80% Co-insurance | 60% Co-insurance |
| Non-Inpatient Lab  | 80% Co-insurance | 60% Co-insurance |
| Outpatient and Freestanding Radiology (excluding CAT Scan and MRI)                       | 80% Co-insurance | 60% Co-insurance |
| Outpatient Dialysis  | 80% Co-insurance | 60% Co-insurance |
| Outpatient Rehabilitative Services   | 80% Co-insurance | 60% Co-insurance |
| Outpatient Surgery   | 80% Co-insurance | 60% Co-insurance |
| Preventive Health Service  | *\$30/Visit      | 60% Co-insurance |
| Well Child Services (Through Age 5)  | *\$30/Visit      | *\$30/Visit      |
| Primary Care Physician Office Visit  | *\$30/Visit      | 60% Co-insurance |
| Routine Gynecological Exam   | *\$30/Visit      | 60% Co-insurance |
| Skilled Nursing Facility/Inpatient Rehabilitation  | 80% Co-insurance | 60% Co-insurance |
| Specialist Office Visit  | *\$30/Visit      | 60% Co-insurance |
| Urgent Care  | 80% Co-insurance | 60% Co-insurance |

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| <b>Waiting Period for Pre-existing</b>  | <b>12 Months</b> |
| <b>Maternity Benefit Waiting Period (available only with Family Coverage)</b> | <b>12 Months</b> |

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| <b>Prescription Drugs</b>                              |                                       |
| Calendar Year Prescription Drug Deductible, Per Member | \$200                                 |
| Generic  | \$10 copay after annual rx deductible |
| Brand-Formulary  | \$25 copay after annual rx deductible |
| Brand-Non-Formulary                                    | \$50 copay after annual rx deductible |

\*Co-payments do not apply to the deductible or Out of pocket maximum