

SCHEDULE OF BENEFITS

PERSONAL INFORMATION

Primary Insured: [John Doe]	Policy Number: [000000000]
Covered Dependents: [Spouse: Mary Doe] [Child: James Doe] [Child: Cindy Doe] [Child:] [Child:] [Child:]	Effective Date: [09-01-03]
	First Renewal Date: [10-01-03]
	Initial Premium: [\$502.04 — includes monthly administration fee]
	Premium Mode: [Monthly]
	Additional Riders: 24-Hour Rider [Optional Primary Insured and Dependent Life Insurance Rider] [Optional Home Health Care and Hospice Care Rider] [Optional Supplemental Accident Rider]

PLAN STRUCTURE – GENERAL BENEFITS (SPECIFIC BENEFITS AND PLAN MAXIMUMS LISTED SEPARATELY)

	In-Network Services	Out-of-Network Services
Your Calendar Year Deductible	[\$2,000][3,000][3,500][5,150][10,000]	[\$4,500][5,500][6,000][7,650][12,500]

	In-Network Services	Out-of-Network Services
Your Benefit Percentage	[50%][80%][100%]	[50%][60%][60%]
Your Coinsurance Percentage	[50%][20%][0%]	[50%][40%][40%]
Your Maximum Coinsurance Limit	[\$2,800][3,200][4,000] [2,800][3,000][4,000][not applicable]	[\$10,000][8,000][Unlimited]
Physician Office Visit	After You meet the Calendar Year Deductible We will pay [50%][80%][100%] and You pay [50%][20%] of Covered Charges until You reach Your Maximum Coinsurance Limit. Thereafter, We pay 100% of the Covered Charges for the Balance of the Calendar Year.	After You meet the Out-of-Network Calendar Year Deductible, We will pay [50][60%] and You pay [50%][40%] of Covered Charges until You reach Your Maximum Coinsurance Limit. Thereafter, We pay 100% of the Covered Charges for the Balance of the Calendar Year.

Emergency Room Services	After You meet the Calendar Year Deductible, We will pay [50%][80%][100%] and You pay [50%][20%][0%] of Covered Charges [until You reach Your Maximum Coinsurance Limit. Thereafter, We pay 100% of the Covered Charges for the balance of the Calendar Year.	After You meet the Calendar Year Deductible, We will pay [50%][80%][100%] and You pay [50%][20%][0%] of Covered Charges [until You reach Your Maximum Coinsurance Limit. Thereafter, We pay 100% of the Covered Charges for the balance of the Calendar Year.
Failure to Certify Penalty	\$500 per Certifiable Service	\$500 per Certifiable Service
Intensive Care	After you meet the Calendar Year Deductible, We will pay [50%][80%][100%] and You will pay [50%][20%][0%] of Covered Charges until you reach Your Maximum Coinsurance Limit. Thereafter, We pay 100% of the Covered Charges for the balance of the Calendar Year.	3 times the semi-private room rate

**PLAN STRUCTURE – SPECIFIC BENEFITS
(GENERAL BENEFITS AND PLAN MAXIMUMS LISTED SEPARATELY)**

Human Organ, Tissue and Bone Marrow Transplant

If Transplant Network is Used	After the Calendar Year Deductible, We will pay [50%][80%][100%] of Covered Charges up to the maximum Coinsurance Limit, then 100% thereafter, up to the Transplant Network Maximum Lifetime Benefit when a Transplant Network is Used.
If Transplant Network is Not Used	After the Calendar Year Deductible, and an additional deductible of \$2,500, We will pay [50%][60%] of Covered Charges, up to the Transplant Network Maximum Lifetime Benefit when a Transplant Network is Not Used.

Manipulative Services	After You meet the Calendar Year Deductible We pay [50%][80%][100%] of Covered Charges, up to the Calendar Year maximum, regardless of whether services are received from a network provider.
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**PLAN MAXIMUMS FOR EACH INSURED PERSON
(GENERAL AND SPECIFIC BENEFITS LISTED SEPARATELY)**

Maximum Benefit For All Injuries and Sicknesses	\$2,000,000 lifetime
Transplant Network Maximum Lifetime Benefit	If Transplant Network is Used \$500,000 If Transplant Network is Not Used \$200,000
Transplant Network Transportation & Lodging Benefit	\$5,000 per covered condition
Ambulance Services (per occurrence)	\$1,000 for ground or water transportation \$5,000 for air transportation
Manipulative Services	\$500 per Calendar Year
Mental or Nervous Disorders Inpatient Treatment Outpatient Treatment Per Calendar Year Maximum Benefit Lifetime Maximum Benefit	30 days of confinement per Calendar Year \$25 per treatment and 26 treatments per Calendar Year \$3,000 \$10,000

Rehabilitative Services	45 days per Sickness or Injury								
Skilled Nursing Facility Services Per Confinement Lifetime Maximum Benefit	60 days 180 days								
Home Health Care Services	40 visits per Calendar Year								
Hospice Care Services	The lesser of 180 days or \$15,000 lifetime								
Therapy Services	30 visits per Sickness or Injury								
Homeopathic Treatment	Up to \$50 per visit and \$500 per Calendar Year								
Therapies for Congenital Defects and Birth Abnormalities (from birth to age 5 – including physical, occupational and speech therapy)	20 visits per Calendar Year.								
Mammography Examinations	Not subject to the Policy Deductible. Benefits are paid at the lesser of [\$76.83] per screening or the actual charge.								
Prostate Examinations	Not subject to the Policy Deductible. Benefits are paid at the lesser of [\$65] per screening or the actual charge.								
Physical Exam Benefit	After Your coverage has been inforce for 12 months, We will pay up to \$500 per person per Calendar Year.								
24-Hour Occupational Coverage Rider	Included								
Prescription Drug Benefit Rider	Subject to In-Network and Out-of-Network Calendar Year Deductible, Coinsurance and Maximum Benefit For All Injuries and Sicknesses								
[Optional Primary Insured and Dependent Life Insurance	<p style="text-align: center;">Death Benefit</p> <table> <tr> <td>Primary Insured</td> <td>\$10,000</td> </tr> <tr> <td colspan="2">After age 70 the Death Benefit reduces by 50%</td> </tr> <tr> <td>Insured Spouse</td> <td>\$10,000</td> </tr> <tr> <td>Dependent Child</td> <td>\$5,000]</td> </tr> </table>	Primary Insured	\$10,000	After age 70 the Death Benefit reduces by 50%		Insured Spouse	\$10,000	Dependent Child	\$5,000]
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[Optional Home Health Care and Hospice Care Rider Home Health Care Hospice Care Benefit Hospice Care Services Bereavement Services	60 visits per Calendar Year limited to 90 days per Calendar Year limited to \$100 per day and 91 days per Benefit Period limited to \$1,170 during the 12 months following death]								
[Optional Supplemental Accident Benefit]	[100% up to [\$500][\$1,000] maximum benefit per accident; any remaining charges beyond the maximum benefit are subject to the Calendar Year Deductible and Coinsurance.]								