

SCHEDULE OF BENEFITS

ELECT FP 2000

MAXIMUM LIFETIME BENEFIT \$2,000,000

ANNUAL DEDUCTIBLE

Participating Provider..... \$2,000 per individual / \$4,000 per family

Nonparticipating Provider..... \$4,000 per individual / \$8,000 per family

The above stated deductible amounts apply to the period of January 1 to December 31 of each year. The deductible is an amount of covered medical expenses the member pays before the plan's benefits begin. The "individual" deductible applies only if the Policyholder enrolls without dependents. If the Policyholder and one or more dependents enroll, only the "family" deductible applies. Only eligible participating provider expense applies to the participating provider deductible and only allowable nonparticipating provider expense applies to the nonparticipating deductible. The deductible applies to all services and supplies except those indicated with a bullet (•).

OUT-OF-POCKET LIMIT

Participating Provider \$5,000 per individual / \$10,000 per family per calendar year

Nonparticipating Provider..... \$10,000 per individual per calendar year

The above stated out-of-pocket limit amounts apply to the period of January 1 to December 31 of each year. Only participating provider expense applies to the participating provide out-of-pocket limit and only nonparticipating provider expense applies to the nonparticipating out-of-pocket limit. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of participating providers' covered charges for the individual for the rest of that calendar year. Once the nonparticipating provider out-of-pocket limit has been met, this plan will pay 100% of nonparticipating providers' covered charges for the individual for the rest of the calendar year. Deductible expense is applied toward the out-of-pocket limit. Benefits paid in full, and charges for services of nonparticipating providers in excess of the allowable amount do not accumulate toward the out-of-pocket limit amount. The individual out-of-pocket limit applies only if the policyholder enrolls without dependents. If one or more dependents enroll, only the family out-of-pocket applies.

ADDITIONAL ACCIDENT BENEFIT \$1,000

The first \$1,000 of covered expense within 90 days of an accident is paid at 100% and is not subject to the deductible. The balance is covered as shown below.

SERVICE:	PARTICIPATING PROVIDER BENEFIT	NONPARTICIPATING PROVIDER BENEFIT
PREVENTIVE CARE		
• Well Baby Care	70%	50%
• Routine Physicals	70%	50%
• Routine Gynecological Exams	70%	50%
• Immunizations	70%	50%
PROFESSIONAL SERVICES		
Office and Home Visits	70%	50%
Urgent Care Center Visits	70%	50%
Surgery	70%	50%
MATERNITY CARE		
Physician Services	70%	50%
Hospital Services	70%	50%
HOSPITAL SERVICES		
Inpatient Room and Board	70%	50%
Inpatient Rehabilitative Care	70%	50%
Skilled Nursing Facility Care	70%	50%
OUTPATIENT SERVICES		
Outpatient Surgery/Services	70%	50%
Diagnostic and Therapeutic Radiology and Lab	70%	50%

SERVICE:	PARTICIPATING PROVIDER BENEFIT	NONPARTICIPATING PROVIDER BENEFIT
CT/PET Scans, CATH Labs and MRIs	70%	50%
Emergency Room Visits	70%	50%
OTHER COVERED SERVICES		
Physical Therapy (20 visits per calendar year)	70%	50%
Allergy Injections	70%	50%
Ambulance, Ground (300 miles per calendar year)	70%	50%
Ambulance, Air (\$6,000 per calendar year)	70%	50%
Durable Medical Equipment (\$7,500 lifetime max.)	70%	50%
Home Health Care	70%	50%
Hospice or Respite Care (\$10,000 lifetime max.)	70%	50%
Inpatient Mental Health (\$1,000 lifetime max.)	70%	50%
Transplant Services (subject to exclusion period and lifetime max)	70%	Lesser of 50% of billed amount or \$100,000
Prescription Drugs	50%	No benefit

- Not subject to deductible.

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, nonparticipating providers may not. Services of nonparticipating providers could result in out-of-pocket expense in addition to the percentage indicated.