SCHEDULE OF BENEFITS

Except as noted, all benefits are subject to the annual plan deductible

UNIVERSAL HEALTH CARE - UNIVERSAL PLUS 5000

Benefit	Member Cost
Allergy Testing	None after Annual deductible
Allergy Treatment	None after Annual deductible
Ambulance	None after Annual deductible
Annual Physical Exam at PCP (Primary Care Physician)	None after Annual deductible
Annual Well Woman Visit includes: 1. Pap Smear 2. Pelvic Exam	None after Annual deductible
Cardiac Rehabilitation	None after Annual deductible - maximum 60 visits per year
Chiropractor	$40 co-pay, max 24 visits per year. Not subject to annual deductible
Cleft Lip and Palate: includes: -speech therapy and nutrition services (covered child under 18)	None after deductible
Complications of Pregnancy	None after deductible
Contraceptive, Oral Generic	None after deductible
Contraceptive, Oral Brand	None after deductible
Deductible per year	$5000
Deductible maximum per family per year	2X deductible
Dental	See Attached Dental Benefit Schedule Not subject to annual deductible
Dental procedures and anesthesia - (covered child under 8, in hospital only)	None after deductible
Dermatologist	None after deductible, Maximum of 5 visits per year w/o a referral
Diagnostic Services:	
1. CT Scan	None after deductible
2. MRI	None after deductible
3. Mammogram at a free-standing Radiology center	None after deductible
4. Nuclear Medicine	None after deductible
5. PET Scan	None after deductible
6. Ultrasound	None after deductible
7. EKG, etc	None after deductible
8. Laboratory	No co-pay, Not subject to annual deductible
9. X-Ray, not otherwise specified	None after deductible
Durable Medical Equipment	$20 co-pay, $1000 max. per year* *max. per year does not apply to diabetic equipment Not subject to annual deductible
Emergency Room Participating Hospital	None after deductible
Emergency Room Non-Participating Hospital	None after deductible
Hearing, Routine Exam (under 18, included in annual physical)	None after deductible (maximum 1 time per year)
Home Health Care	$10 co-pay per day, 60 days maximum per year Not subject to annual deductible
Hospice Facility, In-Patient	None after deductible
Hospice Out Patient	None after deductible
Hospital Deductible (per admission)	None
Hospital, Participating - Inpatient	None after deductible
Hospital Non Par In Service Area - Inpatient	None after deductible
Hospital Outpatient	None after deductible
Immunization (Hepatitis B is not covered except for child under 18)	None after deductible

SCHEDULE OF BENEFITS

Benefit		Member Cost
Lifetime Maximum Benefit		$2,000,000
Mastectomy (surgery, treatment, and reconstruction)		None after deductible
Maternity (if **optional rider** is selected)		$200 Hospital; $20 OB/GYN per visit; $35 Delivery Maternity benefit, if selected, is not subject to the deductible
Mental Health and Substance Abuse - Inpatient (Maximum of 10 days can be used for Substance Abuse)		$200/day for first 2 days; Max 30 days/contract year. Not subject to annual deductible
Mental Health and Substance Abuse - Outpatient (Maximum of 10 visits can be used for Substance Abuse)		$40/visit, Max 30 visits per contract year. Not subject to annual deductible
Office Visit, Primary Care		None after deductible
OB/GYN		None after deductible
Out of pocket maximum		NA
Out of pocket family maximum per year.		NA
Outpatient Surgery Center		None after deductible
Physician Inpatient visits		None after deductible
Podiatrist (routine services not covered)		None after ded., max. 2 visits per year wihout a referral
Prescriptions,	Generic-Formulary	None after deductible
	Brand-Formulary	None after deductible
Prescriptions,	Generic-Formulary	None after deductible
Mail order	Brand-Formulary	None after deductible
Prosthetics and Orthotics		$50 per item; $1000 max per year, Not subject to annual deductible
Rehabilitation - In Patient		None after deductible, max. 15 visits per year
Rehabilitation - Out Patient		None after deductible, max. 60 visits per year
Skilled Nursing Facility	1st thru 7th Day	None after deductible
(Limit of 21 days per year)	8th thru 21st Day	None after deductible
Specialist		None after deductible
Surgery in Office		None after deductible
Therapy: Outpatient		
1. Chemotherapy		None after deductible
2. Hearing Therapy		None after deductible, maximum 60 visits per year
3. Occupational		None after deductible, maximum 60 visits per year
4. Physical Therapy		None after deductible, maximum 60 visits per year
5. Speech		None after deductible, maximum 60 visits per year
6. Radiation		None after deductible
7. Injectable drug therapy (self-injected not covered except for diabetes)		None after deductible
TMJ: Covers: Hospital, surgery, manipulation under anesthesia, exam,and diagnostic x/rays		None after deductible
Transplant (only with plan approval) (Covers: Bone Marrow, Cornea, Heart, Liver (limited), Kidney)		None after deductible
Urgent Care Center - In Network		None after deductible
Urgent Care Center - Out of Network		None after deductible
Vision (Comprehensive Annual Exam)		$0 co-pay
Vision (Frames, Lenses, Contact Lenses)		See attached Vision Benefit Schedule
Vision		Not subject to annual deductible
Well Child Care		None after deductible

* Definitions; For the purpose of this Schedule, the following terms are used: SAAI=Same as any other illness, w/o = Without; Per Year = Per contract year, OV = Office Visit
Out-of-pocket is in addition to the plan deductible