

BROOKLYN HEALTHWORKS SUMMARY OF BENEFITS/COPAYMENT SCHEDULE (continued)

<p>Prescription Drugs</p> <p>Deductible: \$100 per individual per calendar year</p> <p>Copayment: \$10 per generic drug per 34-day supply \$20 per brand name drug plus difference in cost between the brand name drug and its generic equivalent per 34-day supply</p> <p>Mail order program: \$20 per generic drug per 90-day supply \$40 per brand name drug per 90-day supply plus the difference in cost between the brand name drug and its generic equivalent</p> <p>Benefit Maximum: \$3,000 per individual per calendar year</p>
<p>Out-of-Network Benefits – NONE</p> <p>Out-of-network services are not covered except for emergency hospital care. All claims submitted from a provider outside of GHI's tri-state network will not be covered and the individual subscriber will be responsible to pay 100% of the claim.</p>

SERVICES NOT COVERED: Ambulance, Dental Care, Durable Medical Equipment, External Prosthetics, Ostomy Supplies, Mental Health Services, Advance Infertility Services, Chiropractic Care, Skilled Nursing Facility, Speech Therapy, Hospice Care, Chemical Dependency Services.

DENTAL AND VISION PLANS AVAILABLE UPON REQUEST.

PRE-EXISTING CONDITIONS MAY BE EXCLUDED FOR UP TO 12 MONTHS UPON ENROLLMENT WITHOUT PROOF OF PRIOR CREDITABLE COVERAGE.

The benefits described here are only brief highlights of the coverage available. Some benefits may have calendar year limits and/or maximums. The terms, limitations, conditions, and exclusions of the insurance contract and certificate will govern.