

## BENEFIT SUMMARY

	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK</i>
<b>Lifetime Maximum Benefit</b>	\$2,000,000	
<b>Deductible Options</b>		
Maximum 3x Per Family	\$500, \$750, \$1,000, \$2,500, or \$5,000	
<b>Out-of-Pocket Maximum</b>		
Maximum 2x Per Family, Plus Deductible	\$2,500	\$5,000
<b>Physician Office Visits</b>	\$30 copay	50% R&C**
<b>Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology</b>	70%	50% R&C**
<b>Inpatient Hospitalization</b>	70%	50% R&C**
<b>Outpatient Hospital Services</b>	70%	50% R&C**
<b>Hospital Emergency Room Services</b>	\$200 Copay	\$200 Copay
<b>Urgent Care Services</b>	\$75 Copay	50% R&C**
<b>Land/Air Ambulance Services</b>	80%	80%
<b>Maternity/Childbirth Expense Option</b> (12 Month Wait Period)	70%	50% R&C**
<b>Physical / Wellness Examinations</b> (To include well baby, well child, well woman, yearly physicals and/or mammograms & PSA's)	\$300 benefit per calendar year per person not subject to deductible or coinsurance	
<b>Immunizations</b>		
Ages 0 through 4	\$0 Copay per immunization	
Ages 5 and up	70%	50% R&C**
<b>Home Health Care</b> (120 Maximum Visits Per Year)	70%	50% R&C**
<b>Skilled Nursing Facility</b> (90 Maximum Inpatient Days Per Year)	70%	50% R&C**
<b>Hospice Care</b> (\$5,000 Lifetime Maximum Benefit)	70%	50% R&C**
<b>Durable Medical Equipment</b> (\$2,500 / year Maximum Benefit)	70%	50% R&C**
<b>Rehabilitation</b>	70%	50% R&C**
<b>Spinal Manipulation Services</b> (\$250 / year Maximum Benefit)		
Chiropractic Office Visit	Same as for Physician Office Visits	50% R&C**
Other Chiropractic Services	70%	50% R&C**
<b>Mental Health / Substance Abuse</b>		
Mental Health Provider Office Visit	Same as for Physician Office Visits	50% R&C**
Inpatient Services (90-day limit)	70%	50% R&C**
Outpatient Services	70%	50% R&C**
<b>Outpatient Prescription Drugs</b>		
<b>Annual Deductible</b>	\$50, \$75, \$100, \$250, or \$500 (10% of Selected Plan Deductible)	
Tier 1 Copay - Most Generics <sup>1</sup> (30-day supply)	\$10	50% R&C**
Tier 2 Copay - Preferred Brand (30-day supply)	\$35	50% R&C**
Tier 3 Copay - Non-Preferred Formulary Brand (30-day supply)	\$75	50% R&C**
Tier 4 Copay - Specialty (30-day supply)	\$100	N/A
Mail Order (90-day supply)	2.5x Retail Copay	N/A

\*Copay applies ONLY to office visit cost; all diagnostics, x-rays, and treatment will be subject to deductible and coinsurance.

\*\* Reasonable and customary charges.

<sup>1</sup>Generics could fall into any tier. Please consult the formulary.

This is only a brief summary of benefits, which is not intended to be comprehensive. Your Evidence of Coverage is the governing document for benefit information.