

BENEFIT SUMMARY

	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK</i>
Lifetime Maximum Benefit	\$2,000,000	
Deductible Options		
Maximum 3x Per Family	\$500, \$750, \$1,000, \$2,500, or \$5,000	
Out-of-Pocket Maximum		
Maximum 2x Per Family, Plus Deductible	\$2,500	\$5,000
Physician Office Visits	\$30 copay	60% R&C**
Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology	90%	60% R&C**
Inpatient Hospitalization	90%	60% R&C**
Outpatient Hospital Services	90%	60% R&C**
Hospital Emergency Room Services	\$200 Copay	\$200 Copay
Urgent Care Services	\$75 Copay	60% R&C**
Land/Air Ambulance Services	80%	80%
Maternity/Childbirth Expense Option (12 Month Wait Period)	90%	60% R&C**
Physical / Wellness Examinations (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	
Immunizations		
Ages 0 through 4	\$0 Copay per immunization	
Ages 5 and up	90%	60% R&C**
Home Health Care (120 Maximum Visits Per Year)	90%	60% R&C**
Skilled Nursing Facility (90 Maximum Inpatient Days Per Year)	90%	60% R&C**
Hospice Care (\$5,000 Lifetime Maximum Benefit)	90%	60% R&C**
Durable Medical Equipment (\$2,500 / year Maximum Benefit)	90%	60% R&C**
Rehabilitation	90%	60% R&C**
Spinal Manipulation Services (\$250 / year Maximum Benefit)		
Chiropractic Office Visit	Same as for Physician Office Visits	60% R&C**
Other Chiropractic Services	90%	60% R&C**
Mental Health / Substance Abuse		
Mental Health Provider Office Visit	Same as for Physician Office Visits	60% R&C**
Inpatient Services (90-day limit)	90%	60% R&C**
Outpatient Services	90%	60% R&C**
Outpatient Prescription Drugs		
Annual Deductible	\$50, \$75, \$100, \$250, or \$500 (10% of Selected Plan Deductible)	
Tier 1 Copay - Most Generics ¹ (30-day supply)	\$10	60% R&C**
Tier 2 Copay - Preferred Brand (30-day supply)	\$20	60% R&C**
Tier 3 Copay - Non-Preferred Formulary Brand (30-day supply)	\$40	60% 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.

¹Generics 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.