

PLAN FEATURES

IN-NETWORK
Member is responsible for:

OUT-OF-NETWORK
Member is responsible for:

Lifetime Maximum Benefit	\$2,000,000	
Deductible options	\$250, \$500, \$750, \$1,000	2x in-network
Family Maximum = 3x Individual	\$1,500, \$2,500, or \$5,000	
Out-of-Pocket Maximum options	\$1,500, \$2,000, \$2,500,	
Family Maximum = 2x Individual plus Deductible	\$3,000, \$4,000, or \$5,000	2x in-network
Physician Services		
Physician Office Visit	\$20, \$30, or \$40 Copay per visit*	40% R&C**
Physician Services	10%	40% R&C**
Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology	10%	40% R&C**
Inpatient Hospitalization	10%	40% R&C**
Outpatient Hospital Services	10%	40% R&C**
Hospital Emergency Room Services options	\$100 or \$200 copay per visit	\$100 or \$200 copay per visit
Urgent Care Services options	\$75 copay per visit	40% R&C**
Ambulance Services	20%	20% R&C**
Maternity & Childbirth Expenses	10%	40% R&C**
Preventive Services	\$0 Member responsibility for the first \$250 of benefit per calendar year	
Physician Office Visit Only	Copay is same as for Physician Services	40% R&C**
Children Services (0-12 years)	10%	40% R&C**
Adolescent & Adult Services (ages 13 to Adult)	10%	40% R&C**
Immunizations		
Ages 0 through 4	\$0 Copay per immunization	
Ages 5 and up	\$12 Copay per immunization	
Home Health Care	10%	40% R&C**
Skilled Nursing Facility	10%	40% R&C**
Hospice Care	10%	40% R&C**
Durable Medical Equipment (\$2,500 / year Maximum Benefit)	10%	40% R&C**
Disposable Medical Supplies (\$2,000 / year Maximum Benefit)	10%	40% R&C**
Chiropractic Services	(Limited to 26 per calendar year)	
Chiropractic Office Visit	Copay is same as Physician Office Visit	40% R&C**
Other Chiropractic Services	10%	40% R&C**
Mental Health / Substance Abuse		
Mental Health Provider Office Visit	Copay is same as Physician Office Visit	40% R&C**
Inpatient Services	10%	40% R&C**
Outpatient Services	10%	40% R&C**
Outpatient Prescription Drugs options	After satisfaction of \$0, \$50, \$100, or \$250 Rx Deductible	
Tier 1 - Most Generics ¹ (30-day supply)	\$10 or \$10	40%
Tier 2 - Preferred Brand (30-day supply)	\$20 \$35	40%
Tier 3 - Non-Preferred Formulary Brand (30-day supply)	\$40 \$75	40%
Tier 4 - Specialty Formulary Brand (30-day supply)	\$100 \$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.

¹ Generics could fall into any tier. Please consult the formulary.

No benefit combination to equal more than 30% difference between In-Network and Out-of-Network coinsurances.

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.