

## PLAN FEATURES

**IN NETWORK**  
Member is responsible for:

<b>Lifetime Maximum Benefit</b>	Unlimited
<b>Deductible options</b>	
Per Covered Person	\$0
Per Family	\$0
<b>Coinsurance Percentage options</b>	
Choose one: The chosen percentage is the amount for which the member is responsible after the deductible and applies to all percentage options below.	10%
	20%
	30%
<b>Coinsurance Maximum options</b> (plus deductible, if applicable)	
Per Covered Person	\$1,000
	\$2,000
	\$3,000
	\$4,000
Per Family	3x Individual
<b>Office Visit Copay options</b>	\$20, \$30, or \$40**
<b>Physician Services</b>	Coinsurance
<b>Inpatient Hospitalization</b>	Coinsurance
<b>Outpatient Hospital Services</b>	Coinsurance
<b>Hospital Emergency Room Services options</b>	\$75 or \$150 <sup>1</sup>
<b>Urgent Care Services options</b>	\$40 or \$50 <sup>1</sup>
<b>Ambulance Services</b>	Coinsurance
<b>Home Health Care</b>	Coinsurance
<b>Skilled Nursing Facility</b> (100 days / year Maximum Benefit)	Coinsurance
<b>Hospice Care</b>	Coinsurance
<b>Durable Medical Equipment</b> (\$2,500 / year Maximum Benefit)	Coinsurance
<b>Disposable Medical Supplies</b> (\$2,000 / year Maximum Benefit)	Coinsurance
<b>Prosthetics</b>	Coinsurance
<b>Orthotics</b> (Applies to DME Maximum Benefit)	50%

	<b>CARE RECEIVED IN PHYSICIAN'S OFFICE SETTING</b> Member is responsible for:	<b>CARE RECEIVED IN OTHER THAN OFFICE SETTING</b> Member is responsible for:
<b>Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology</b>	Copay**	Coinsurance
<b>Preventive Services</b>		
Routine Physicals	Copay**	Coinsurance
Well Woman Exam & Lab, Routine Mammogram	Copay** per billed service	Coinsurance
Prostate Screening & Lab, Colorectal Screening & Lab	Copay** per billed service	Coinsurance
<b>Maternity &amp; Childbirth Expenses</b>	Copay**	Coinsurance
<b>Immunizations</b>		
Ages 0 through 4	\$0 Copay per immunization	\$0 Copay per immunization
Ages 5 and up	Copay**	Coinsurance
<b>Chiropractic Services</b> (Limited to 26 visits per calendar year)	Copay**	Coinsurance
<b>Mental Health / Substance Abuse</b>		
Mental Health Provider Office Visit	Copay**	n/a
Inpatient Services	n/a	Coinsurance
<b>Covered Education</b>	Copay**	Coinsurance
<b>Outpatient Prescription Drugs options</b>		
Tier 1 - Most Generics <sup>2</sup> (30-day supply)	\$8 or \$10	
Tier 2 - Preferred Brand (30-day supply)	\$25 \$35	
Tier 3 - Non-Preferred Formulary Brand (30-day supply)	\$45 \$75	
Tier 4 - Specialty Formulary Brand (30-day supply)	\$100 \$100	
Mail Order (90-day supply)	2.5x Retail Copay	

\*\*Copay applicable for all services received in and billed through a physician's office. Care not received in an office setting is subject to coinsurance.

<sup>1</sup> Medically necessary emergency benefits will be provided temporarily out of network when services are immediately required until condition permits travel or transport into network.

<sup>2</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.