

## BENEFIT SUMMARY

### Traditional

### Value First

PLAN FEATURES	In-Network		Out-of-Network		In-Network		Out-of-Network		
<b>Lifetime Maximum Benefit</b>	\$2,000,000				\$2,000,000				
<b>Deductible Options</b> (Maximum 3x per Family)	\$500	\$750	\$1,000	\$2,500	\$5,000	\$1,000	\$2,500	\$5,000	\$10,000
<b>Outpatient Prescription Drugs</b>									
Rx Deductible	\$50	\$75	\$100	\$250	\$500	\$2000			
	(10% of Selected Plan Deductible)								
Generic (30-day supply)	\$10 Copay					\$10 Copay			
Preferred Brand / Formulary (30-day supply)	\$20 Copay			60%		\$20 Copay		50%	
Other Brand / Non-Formulary (30-day supply)	\$40 Copay					\$40 Copay			
<b>Out-of-Pocket Maximum</b>									
Maximum 2x Per Family, Plus Deductible	\$2,500		\$5,000		\$3,000		\$6,000		
<b>Physician Office Visits</b>									
(If \$30 Copay is not chosen, Physician office visit will be applied to deductible or paid at 90% after deductible is met.)	Optional		60% R&C**		Optional		50% R&C**		
	\$30 Copay				\$30 Copay				
<b>Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology</b>	90%		60% R&C**		80%		50% R&C**		
<b>Inpatient Hospitalization</b>	90%		60% R&C**		80%		50% R&C**		
<b>Outpatient Hospital Services</b>	90%		60% R&C**		80%		50% R&C**		
<b>Hospital Emergency Room Services</b>	90%		60% R&C**		80%		50% R&C**		
<b>Urgent Care Services</b>	90%		60% R&C**		80%		50% R&C**		
<b>Land/Air Ambulance Services</b>	80%		80%		80%		80%		
<b>Maternity &amp; Childbirth Expenses</b> (12 month waiting period)	90%		60% R&C**		80%		50% R&C**		
<b>Preventive Services</b> (To include well-baby, well-child, well-woman, yearly physicals, and/or mammograms & PSAs)	\$200 per year not subject to deductible & coinsurance				\$200 per year not subject to deductible & coinsurance				
	90%		60% R&C**		80%		50% R&C**		
<b>Home Health Care</b> (120 days per year limit)	90%		60% R&C**		80%		50% R&C**		
<b>Skilled Nursing Facility</b> (90 inpatient days per year limit)	90%		60% R&C**		80%		50% R&C**		
<b>Hospice Care</b> (Lifetime Max of \$5,000)	90%		60% R&C**		80%		50% R&C**		
<b>Durable Medical Equipment</b> (\$2,500 Max per year)	90%		60% R&C**		80%		50% R&C**		
<b>Rehabilitation</b>	90%		60% R&C**		80%		50% R&C**		
<b>Spinal Manipulation Services</b> (\$250 per year maximum benefit)	90%		60% R&C**		80%		50% R&C**		
<b>Mental Health / Chemical Dependency</b>	Same as physician services				Same as physician services				
Mental Health Provider Office Visit			60% R&C**				50% R&C**		
Inpatient Services (90 days per year limit)	90%		60% R&C**		80%		50% R&C**		
Outpatient Services	90%		60% R&C**		80%		50% R&C**		



**Our Child-Only Plan is available with either the Traditional or Value First benefit design.  
(Maternity benefits excluded on both).**

\* Copay applies ONLY to office visit cost; all diagnostics, x-rays, and treatment will be subject to deductible and coinsurance.  
\*\* All Out-of-Network charges are subject to Reasonable and Customary charge reductions.

**This is only a brief summary of benefits, which is not intended to be comprehensive.  
Your policy document, issued when coverage is approved, is the governing document for benefit information.**