

PLAN FEATURES

IN-NETWORK
Member is responsible for:

OUT-OF-NETWORK
Member is responsible for:

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

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

** Reasonable and customary charges.

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.