

## PLAN FEATURES

*IN-NETWORK*  
*Member is responsible for:*

*OUT-OF-NETWORK*  
*Member is responsible for:*

<b>Lifetime Maximum Benefit</b>	\$2,000,000	
<b>Deductible</b>	\$250, \$500, \$750	2x in-network
Maximum 3x Per Family	\$1,000, \$1,500, \$2,500, \$5,000	
<b>Out-Of-Pocket Maximum</b>		
Maximum 2x Per Family, Plus Deductible	\$2,500, \$3,000	2.5x in-network
<b>Physician Services</b>		
Physician Office Visit	\$20, \$30, \$40 Copay per visit*	50% R&C **
Physician Services	20%	50% R&C **
<b>Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology</b>	20%	50% R&C **
<b>Inpatient Hospitalization</b>	20%	50% R&C **
<b>Outpatient Hospital Services</b>	20%	50% R&C **
<b>Hospital Emergency Room Services</b>	20%	20%
<b>Urgent Care Services</b>	20%	50% R&C **
<b>Ambulance Services</b>	20%	20% R&C **
<b>Maternity &amp; Childbirth Expenses</b>	20%	50% R&C **
<b>Preventive Services</b>	\$0 Member responsibility for the first \$250 of benefit per calendar year	
Physician Office Visit Only	Copay is same as for Physician Services	50% R&C **
Children Services (0-12 years)	20%	50% R&C **
Adolescent & Adult Services (Ages 13 to Adult)	20%	50% R&C **
<b>Immunizations</b>		
Ages 0 through 4	\$0 Copay per immunization	
Ages 5 and up	\$12 Copay per immunization	
<b>Home Health Care</b>	20%	50% R&C **
<b>Skilled Nursing Facility</b>	20%	50% R&C **
<b>Hospice Care</b>	20%	50% R&C **
<b>Durable Medical Equipment</b> (\$2,500 / year Maximum Benefit)	20%	50% R&C **
<b>Disposable Medical Supplies</b> (\$2,000 / year Maximum Benefit)	20%	50% R&C **
<b>Chiropractic Services</b>	(Limited to 26 per calendar year)	
Chiropractic Office Visit	Copay is same as for Physician Services	50% R&C **
Other Chiropractic Services	20%	50% R&C **
<b>Mental Health / Substance Abuse</b>		
Mental Health Provider Office Visit	Copay is same as for Physician Services	50% R&C **
Inpatient Services	20%	50% R&C **
Outpatient Services	20%	50% R&C **
<b>Outpatient Prescription Drugs</b>	After satisfaction of \$100 Rx Deductible	
Generic (30-day supply)	\$10	50%
Preferred Brand / Formulary (30-day supply)	\$20	50%
Other Brand / Non-Formulary (30-day supply)	\$40	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.