

PLAN FEATURES

	<i>HMO</i>	<i>POS</i>
Lifetime Maximum Benefit	Unlimited	\$1,000,000
Deductible		
Per Covered Person	n/a	\$500, \$1,000
Per Family	n/a	3x Individual
Coinsurance Percentage		
Choose one: The chosen percentage is the amount the plan covers after the deductible and applies to all percentage options below.	90%	70%
	80%	60%
	70%	50%
Coinsurance Maximum (Plus Deductible, if applicable)		
Per Covered Person	\$1,000	\$2,000, \$3,000, \$6,000
Per Family	\$2,000 3x Individual	\$3,000, \$6,000 4x Individual
Office Visit Copay	\$20, \$30	Subject to Deductible & Coinsurance*
Physician Services	Copay**	Subject to Deductible & Coinsurance*
Inpatient Hospitalization	Subject to Coinsurance	Subject to Deductible & Coinsurance*
Outpatient Hospital Services	Subject to Coinsurance	Subject to Deductible & Coinsurance*
Hospital Emergency Room Services	\$75	\$75
Urgent Care Services	\$40	\$40
Ambulance Services	Subject to Coinsurance	Subject to Deductible & Coinsurance*
Home Health Care	Subject to Coinsurance	Not Covered
Skilled Nursing Facility	Subject to Coinsurance	Subject to Deductible & Coinsurance*
Hospice Care	Subject to Coinsurance	Not Covered
Durable Medical Equipment (\$2,500/year Maximum Benefit)	Subject to Coinsurance	Subject to Deductible & Coinsurance*
Disposable Medical Supplies (\$2,000/year Maximum Benefit)	Subject to Coinsurance	Subject to Deductible & Coinsurance*
Prosthetics	Subject to Coinsurance	Subject to Deductible & Coinsurance*
Orthotics (Applies to DME Maximum Benefit)	50%	Subject to Deductible & 50% Coinsurance*
<p>Services listed below: For care received in a Physician's office, the Member is responsible for a copay. For care not received in an office setting, the Member is responsible for coinsurance.</p>		
Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology	Copay**	Subject to Deductible & Coinsurance*
Preventive Services		
Routine Physicals	Copay**	Not Covered
Well Woman Exam and Lab, Routine Mammogram	Copay**	Subject to Deductible & Coinsurance*
Prostate Screening, Colorectal Screening	Copay**	Subject to Deductible & Coinsurance*
Maternity & Childbirth Expenses	Copay**	Subject to Deductible & Coinsurance*
Immunizations		
Ages 0 through 4	\$0 Copay per immunization	Not Covered
Ages 5 and up	Copay**	Not Covered
Chiropractic Services	(Limited to 26 per calendar year)	
Chiropractic Office Visit	Copay**	Not Covered
Mental Health / Substance Abuse		
Mental Health Provider / Office Visit	Copay**	Not Covered
Inpatient Services	Coinsurance	Not Covered
Covered Education	Copay**	Not Covered
Outpatient Prescription Drugs		
Generic (30-day supply)	\$8	Members must pay the full cost of the prescription.
Preferred Brand / Formulary (30-day supply)	\$25	
Other Brand / Non-Formulary (30-day supply)	\$45	

*Under the terms of the POS rider, the Member is responsible for any charges in excess of Usual & Customary.

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

The maximums identified are accumulated separately for HMO and POS, including deductibles and coinsurance.

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.