

BENEFIT SUMMARY

	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK</i>	
Essential Benefits¹	\$2,000,000 per year ¹		
Lifetime Maximum Benefit	Unlimited		
Deductible Options	\$500, \$750, \$1000, \$2500, or \$5000		
Maximum 3x Per Family			
Co-Insurance Options	90% or 70%	60% or 50% U&C**	
Out-of-Pocket Maximum	\$2500	\$5000	
Maximum 2x Per Family, Plus Deductible			
Physician Office Visits	\$30 Copay*	60% or 50% U&C**	
Chiropractic Office Visit (26 Maximum Visits Per Year)	Same as "Physician Office Visits"	60% or 50% U&C**	
Other Chiropractic Services	90% or 70%	60% or 50% U&C**	
Mental Health/Substance Abuse			
Mental Health Provider Office Visit	Same as "Physician Office Visits"	60% or 50% U&C**	
Inpatient Services (90-day limit)	90% or 70%	60% or 50% U&C**	
Outpatient Services	90% or 70%	60% or 50% U&C**	
Preventive/Wellness Examinations			
Eligible Expenses Covered at 100% (no deductible)	100% ²	60% or 50% U&C**	
Immunizations			
Eligible Expenses Covered at 100% (no deductible)	100% ²	60% or 50% U&C**	
Hospital Emergency Room Services	\$200 Copay	\$200 Copay	
Urgent Care Services	\$75 Copay	60% or 50% U&C**	
Land/Air Ambulance Services	80%	80%	
Maternity & Childbirth Expense Option (12-Month Wait Period)	90% or 70%	60% or 50% U&C**	
Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology	90% or 70%	60% or 50% U&C**	
Inpatient Hospitalization	90% or 70%	60% or 50% U&C**	
Outpatient Hospital Services	90% or 70%	60% or 50% U&C**	
Home Health Care (120 Maximum Visits Per Year)	90% or 70%	60% or 50% U&C**	
Skilled Nursing Facility (90 Maximum Inpatient Days Per Year)	90% or 70%	60% or 50% U&C**	
Hospice Care	90% or 70%	60% or 50% U&C**	
Durable Medical Equipment	90% or 70%	60% or 50% U&C**	
Rehabilitation	90% or 70%	60% or 50% U&C**	
Outpatient Prescription Drugs			
Annual Deductible	\$50, \$75, \$100, \$250 or \$500 (10% of Selected Plan Deductible)		
	90% Plan	70% Plan	
Tier 1 Copay - Most Generics ³ (30-day supply)	\$10	\$10	60% or 50% U&C**
Tier 2 Copay - Preferred Brand (30-day supply)	\$20	\$35	60% or 50% U&C**
Tier 3 Copay - Non-Preferred Formulary Brand (30-day supply)	\$40	\$75	60% or 50% U&C**
Tier 4 Copay - Specialty (30-day supply)	\$100	\$100	N/A
Mail Order (90-day supply)	2.5 x Retail Copay		N/A

¹As defined by Health Reform Law as "Essential Benefits"

²Preventive/Wellness Examinations & Immunizations – services recommended by the U.S. Preventive Task Force. Additional office services not mandated by PHSA Section 2713 subject to deductible and co-insurance.

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

**Usual and Customary (U&C) charges.

³Generics 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 Individual Health Plan Benefit Booklet is the governing document for the benefit information.