

PLAN FEATURES

	<i>HMO</i> Member is responsible for:	<i>POS options</i> Member is responsible for:
Essential Benefits		\$2,000,000 per year
Lifetime Maximum Benefit		Unlimited
Deductible options		
Per Covered Person	n/a	\$500 or \$1,000
Per Family	n/a	3x Individual
Coinsurance Percentage options	10%, 20%, 30%	30% (10%), 40% (20%), 50% (30%)
Coinsurance Maximum options (plus deductible, if applicable)		
Per Covered Person	\$1,000 \$2,000 \$3,000 \$4,000	\$2,000, \$3,000 or \$6,000 \$3,000 or \$6,000 \$4,000 or \$6,000 \$5,000 or \$6,000
Per Family	3x Individual	4x Individual
Office Visit Copay options	\$20, \$30, or \$40**	Deductible & Coinsurance*
Physician Services not received in an office setting	Coinsurance	Deductible & Coinsurance*
Inpatient Hospitalization	Coinsurance	Deductible & Coinsurance*
Outpatient Hospital Services	Coinsurance	Deductible & Coinsurance*
Hospital Emergency Room Services options	\$75 or \$150 ¹	Deductible & Coinsurance* ¹
Urgent Care Services options	\$40 or \$50	Deductible & Coinsurance*
Ambulance Services	Coinsurance	Deductible & Coinsurance*
Home Health Care	Coinsurance	Not Covered
Hospice Care	Coinsurance	Not Covered
Skilled Nursing Facility (100 days / year Maximum Benefit)	Coinsurance	Deductible & Coinsurance*
Durable Medical Equipment	Coinsurance	Deductible & Coinsurance*
Disposable Medical Supplies	Coinsurance	Deductible & Coinsurance*
Prosthetics	Coinsurance	Deductible & Coinsurance*
Orthotics	50%	Deductible & Coinsurance*
Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology	Copay**	Deductible & Coinsurance*
Preventive Health Services		
Preventive Services as mandated by PHSA Section 2713	\$0	Deductible & Coinsurance*
Physician office visits & lab associated with checkups	\$0	Deductible & Coinsurance*
Additional preventive services not mandated by PHSA Sect. 2713	Copay**	Deductible & Coinsurance*
Maternity & Childbirth Expenses	Coinsurance	Deductible & Coinsurance*
Immunizations (per immunization)		
Ages 0 through Adult as mandated by PHSA Section 2713	\$0	Deductible & Coinsurance*
Additional immunizations not mandated by PHSA Section 2713	Copay**	Deductible & Coinsurance*
Chiropractic Office Visits	Copay**	Not Covered
Mental Health / Substance Abuse		
Mental Health Provider Office Visit	Copay**	Deductible & Coinsurance*
Inpatient/Outpatient/Residential Services	Coinsurance	Deductible & Coinsurance*
Outpatient Prescription Drugs options		
Tier 1 - Most Generics ² (30-day supply)	\$8 or \$10	Not Covered
Tier 2 - Preferred Brand (30-day supply)	\$25 \$35	Not Covered
Tier 3 - Non-Preferred Formulary Brand (30-day supply)	\$45 \$75	Not Covered
Tier 4 - Specialty Formulary Brand (30-day supply)	\$100 \$100	Not Covered
Mail Order (90-day supply)	2.5x Retail Copay	Not Covered

*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. eVisit subject to \$10 copay.

¹ Medically necessary emergency benefits will be provided temporarily out of network when services are immediately required until condition permits travel or transport into network.

² Generics could fall into any tier. Please consult the formulary.

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.