

**PLAN FEATURES**

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

<b>Essential Benefits</b>	\$2,000,000 per year	
<b>Lifetime Maximum Benefit</b>	Unlimited	
<b>Deductible options</b>	\$250, \$500, \$750, \$1,000	2x in-network
Family Maximum = 3x Individual	\$1,500, \$2,500, or \$5,000	
<b>Out-of-Pocket Maximum options</b>	\$1,500, \$2,000, \$2,500,	
Family Maximum = 2x Individual plus Deductible	\$3,000, \$4,000, or \$5,000	2x in-network
<b>Physician Services</b>		
Physician Office Visit	\$20, \$30, or \$40 Copay per visit*	40% U&C**
Physician Services	10%	40% U&C**
<b>Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology</b>	10%	40% U&C**
<b>Inpatient Hospitalization</b>	10%	40% U&C**
<b>Outpatient Hospital Services</b>	10%	40% U&C**
<b>Hospital Emergency Room Services options</b>	\$100 or \$200 copay per visit	\$100 or \$200 copay per visit
<b>Urgent Care Services options</b>	\$75 copay per visit	40% U&C**
<b>Ambulance Services</b>	20%	20% U&C**
<b>Maternity &amp; Childbirth Expenses</b>	10%	40% U&C**
<b>Preventive Health Services</b>	Services as mandated by PHSA Section 2713	
Services recommended by the U.S. Preventive Task Force	\$0	40% U&C**
Preventive office visits & lab associated with checkups	\$0	40% U&C**
Additional office services not mandated by PHSA Section 2713	Copay is same as Physician Office Visit	40% U&C**
<b>Immunizations</b>		
Ages 0 to Adult - as mandated by PHSA Section 2713	\$0 Copay per immunization	40% U&C**
Additional immunizations not mandated by PHSA Section 2713	\$12 copay per immunization	40% U&C**
<b>Home Health Care</b>	10%	40% U&C**
<b>Skilled Nursing Facility</b>	10%	40% U&C**
<b>Hospice Care</b>	10%	40% U&C**
<b>Durable Medical Equipment</b>	10%	40% U&C**
<b>Disposable Medical Supplies</b>	10%	40% U&C**
<b>Chiropractic Services</b>	(Limited to 26 per calendar year without prior authorization)	
Chiropractic Office Visit	Copay is same as Physician Office Visit	40% U&C**
Other Chiropractic Services	10%	40% U&C**
<b>Mental Health / Substance Abuse</b>		
Mental Health Provider Office Visit	Copay is same as Physician Office Visit	40% U&C**
Inpatient Services	10%	40% U&C**
Outpatient Services	10%	40% U&C**
<b>Outpatient Prescription Drugs options</b>	After satisfaction of \$0, \$50, \$100, or \$250 Rx Deductible	
Tier 1 - Most Generics <sup>1</sup> (30-day supply)	\$10 or \$10	40%
Tier 2 - Preferred Brand (30-day supply)	\$20 \$35	40%
Tier 3 - Non-Preferred Formulary Brand (30-day supply)	\$40 \$75	40%
Tier 4 - Specialty (30-day supply)	\$100 \$100	N/A
Mail Order (90-day supply)	2.5x Retail Copay	N/A

\*Copay applies ONLY to office visit cost; all diagnostics, x-rays, and treatment will be subject to deductible and coinsurance. eVisits subject to \$10 copay.

\*\* Usual and customary charges.

<sup>1</sup> Generics could fall into any tier. Please consult the formulary.

No benefit combination to equal more than 30% difference between In-Network and Out-of-Network coinsurances.

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.