

## PLAN FEATURES

	<i>HMO</i> Member is responsible for:	<i>POS</i> Member is responsible for:
<b>Lifetime Maximum Benefit</b>	Unlimited	\$1,000,000
<b>Deductible options</b>		
Per Covered Person	n/a	\$500 or \$1,000
Per Family	n/a	3x Individual
<b>Coinsurance Percentage options</b>		
Choose one: The chosen percentage is the amount for which the member is responsible after the deductible and applies to all percentage options below.	10%	30%
	20%	40%
	30%	50%
<b>Coinsurance Maximum options</b> (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
<b>Office Visit Copay options</b>	\$20, \$30, or \$40**	Deductible & Coinsurance*
<b>Physician Services</b>	Coinsurance	Deductible & Coinsurance*
<b>Inpatient Hospitalization</b>	Coinsurance	Deductible & Coinsurance*
<b>Outpatient Hospital Services</b>	Coinsurance	Deductible & Coinsurance*
<b>Hospital Emergency Room Services options</b>	\$75 or \$150 <sup>1</sup>	Deductible & Coinsurance* <sup>1</sup>
<b>Urgent Care Services options</b>	\$40 or \$50 <sup>1</sup>	Deductible & Coinsurance* <sup>1</sup>
<b>Ambulance Services</b>	Coinsurance	Deductible & Coinsurance*
<b>Home Health Care</b>	Coinsurance	Not Covered
<b>Skilled Nursing Facility</b> (100 days / year Maximum Benefit)	Coinsurance	Deductible & Coinsurance*
<b>Hospice Care</b>	Coinsurance	Not Covered
<b>Durable Medical Equipment</b> (\$2,500 / year Maximum Benefit)	Coinsurance	Deductible & Coinsurance*
<b>Disposable Medical Supplies</b> (\$2,000 / year Maximum Benefit)	Coinsurance	Deductible & Coinsurance*
<b>Prosthetics</b>	Coinsurance	Deductible & Coinsurance*
<b>Orthotics</b> (Applies to DME Maximum Benefit)	50%	Deductible & Coinsurance*
<p>Services listed below:            For care received in a Physician's office, the member is responsible for copay.            For care not received in an office setting, the Member is responsible for coinsurance.</p>		
<b>Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology</b>	Copay**	Deductible & Coinsurance*
<b>Preventive Services</b>		
Routine Physicals	Copay**	Not Covered
Well Woman Exam & Lab, Routine Mammogram	Copay** per billed service	Deductible & Coinsurance*
Prostate Screening & Lab, Colorectal Screening & Lab	Copay** per billed service	Deductible & Coinsurance*
<b>Maternity &amp; Childbirth Expenses</b>	Copay**	Deductible & Coinsurance*
<b>Immunizations</b>		
Ages 0 through 4	\$0 Copay per immunization	Not Covered
Ages 5 and up	Copay**	Not Covered
<b>Chiropractic Office Visits</b> (Limited to 26 per calendar year)	Copay**	Not Covered
<b>Mental Health / Substance Abuse</b>		
Mental Health Provider Office Visit	Copay**	Not Covered
Inpatient Services	Coinsurance	Not Covered
<b>Covered Education</b>	Copay**	Not Covered
<b>Outpatient Prescription Drugs options</b>		
Tier 1 - Most Generics <sup>2</sup> (30-day supply)	\$8 or \$10	Members must pay the full cost of the prescription.
Tier 2 - Preferred Brand (30-day supply)	\$25 \$35	
Tier 3 - Non-Preferred Formulary Brand (30-day supply)	\$45 \$75	
Tier 4 - Specialty Formulary Brand (30-day supply)	\$100 \$100	
Mail Order (90-day supply)	2.5x Retail Copay	

\*Under the terms of the POS rider, the Member is responsible for any charges in excess of Usual & Customary. <sup>2</sup> Generics could fall into any tier. Please consult the formulary.  
 \*\*Copay applicable for all services received in a physician's office. Care not received in an office setting is subject to coinsurance.  
<sup>1</sup> Medically necessary emergency benefits will be provided temporarily out of network when services are immediately required until condition permits travel or transport into network. 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.