

## BENEFIT SUMMARY

	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK</i>
<b>Essential Benefits<sup>1</sup></b>	\$2,000,000 per year <sup>1</sup>	
<b>Lifetime Maximum Benefit</b>	Unlimited	
<b>Deductible Options</b>	\$1000, \$2500, \$5000, or \$10,000	
Maximum 3x Per Family		
<b>Co-Insurance</b>	80%	50% U&C**
<b>Out-of-Pocket Maximum</b>	\$3000	\$6000
Maximum 2x Per Family, Plus Deductible		
<b>Physician Office Visits</b>	80%	50% U&C**
Optional Unlimited \$30 Copay – \$15 additional premium per person	\$30 Copay* Option	50% U&C**
<b>Chiropractic Office Visit</b> (26 Maximum Visits Per Year)	Same as “Physician Office Visits”	50% U&C**
Other Chiropractic Services	80%	50% U&C**
<b>Mental Health/Substance Abuse</b>		
Mental Health Provider Office Visit	Same as “Physician Office Visits”	50% U&C**
Inpatient Services (90-day limit)	80%	50% U&C**
Outpatient Services	80%	50% U&C**
<b>Preventive/Wellness Examinations</b>		
Eligible Expenses Covered at 100% (no deductible)	100% <sup>2</sup>	50% U&C**
<b>Immunizations</b>		
Eligible Expenses Covered at 100% (no deductible)	100% <sup>2</sup>	50% U&C**
<b>Hospital Emergency Room Services</b>	80%	50% U&C**
<b>Urgent Care Services</b>	80%	50% U&C**
<b>Land/Air Ambulance Services</b>	80%	50% U&C**
<b>Maternity &amp; Childbirth Expense Option</b> (12-Month Wait Period)	80%	50% U&C**
<b>Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology</b>	80%	50% U&C**
<b>Inpatient Hospitalization</b>	80%	50% U&C**
<b>Outpatient Hospital Services</b>	80%	50% U&C**
<b>Home Health Care</b> (120 Maximum Visits Per Year)	80%	50% U&C**
<b>Skilled Nursing Facility</b> (90 Maximum Inpatient Days Per Year)	80%	50% U&C**
<b>Hospice Care</b>	80%	50% U&C**
<b>Durable Medical Equipment</b>	80%	50% U&C**
<b>Rehabilitation</b>	80%	50% U&C**
<b>Outpatient Prescription Drugs</b>		
<b>Annual Deductible</b>	\$2000	
Tier 1 Copay - Most Generics <sup>3</sup> (30-day supply)	\$10	50% U&C**
Tier 2 Copay - Preferred Brand (30-day supply)	\$20	50% U&C**
Tier 3 Copay - Non-Preferred Formulary Brand (30-day supply)	\$40	50% U&C**
Tier 4 Copay - Specialty (30-day supply)	\$100	N/A
Mail Order (90-day supply)	2.5 x Retail Copay	N/A

<sup>1</sup>As defined by Health Reform Law as “Essential Benefits”

<sup>2</sup>Preventive/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.

\*Optional Copay applies ONLY to office visit cost; all diagnostic, x-rays, and treatment will be subject to deductible and coinsurance. The Copay option is available for \$15 additional premium per person per month.

\*\*All Out-of-Network charges are subject to Usual and Customary (U&C) charge reductions.

<sup>3</sup>Generics 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.