



Highlights of Your Standard Benefits...

What You Pay

	HMO	HMO/POS (within network)	HMO/POS (Out-of-Network) after deductible
*Doctor's Services			
Allergy Testing and Treatment	\$ 15.00/visit	\$ 10.00/visit	20%
Anesthesia	\$ 15.00/visit	\$ 10.00/visit	20%
Delivery of Child	20% up to \$200	\$ 10.00	20%
Diagnostic Services and Treatments	\$ 15.00/visit	\$ 10.00/visit	20%
Mammography Screening	15.00/visit	\$ 10.00/visit	20%
Obstetrical/Gynecological Services	\$ 15.00/visit	\$ 10.00/visit	20%
Office Visits	\$ 15.00/visit	\$ 10.00/visit	20%
Pre- and Post-Natal Care	No Cost	No Cost	20%
Radiation Therapy and Chemotherapy	\$ 15.00/visit	\$ 10.00/visit	20%
Second Surgical Opinions	\$ 15.00/visit	No Cost	0%**
Surgical Services (per occurrence)	20% up to \$200	\$ 10.00/visit	20%
Well-Child Care (including immunizations)	No Cost	No Cost	Not Covered
X-ray and Laboratory Services	\$ 15.00/visit	\$ 10.00/visit	20%
Hospital Services			
Inpatient Admission	\$500.00	No Cost	20%
Outpatient Surgery	\$ 75.00/visit	No Cost	20%
Ambulance Service	No Cost	No Cost	20%
Emergency Room Care (no admission to hospital)	\$ 50.00/visit	\$ 35.00/visit	20%
Hospital Alternatives			
Skilled Nursing Facility	No Cost	No Cost	20%
Home Health Care (200 visit limit)	\$ 15.00/visit	\$ 10.00/visit	20%**
Hospice Care – Inpatient ***	\$500.00	No Cost	20%
Hospice Care – Outpatient ***	\$ 15.00/visit	\$ 10.00/visit	20%
Private Duty Nursing (\$5,000 maximum per calendar year, \$10,000 lifetime maximum)	\$ 15.00/visit	\$ 10.00/visit	20%
Rehabilitative Services			
Physical Therapy – Inpatient	\$500.00	No Cost	20%
Physical Therapy – Outpatient (limited to 90 days per condition, per calendar year)	\$ 15.00/visit	\$ 10.00/visit	20%
Prescription Drugs			
<i>Subject to a \$100.00 deductible per individual per calendar year. \$300.00 per family per calendar year maximum deductible.</i>			
Retail – 34 day supply			
Generic	\$ 5.00	\$ 5.00	Not Covered
Brand Name	\$ 10.00	\$ 10.00	Not Covered
Mail Order – 90 day supply			
Generic	\$ 10.00**	\$ 10.00**	Not Covered
Brand Name	\$ 20.00**	\$ 20.00**	Not Covered

(** not subject to deductible)

(*** combined benefits of 210 days)

...And Your Out-of-Pocket Costs

What You Pay

	HMO	HMO/POS (within network)	HMO/POS (Out-of-Network) after deductible
Alcoholism, Substance Abuse and Mental and Nervous Conditions			
Mental Health – Inpatient Admission (limited to 30 days combined with inpatient detoxification benefit)	\$500.00	No Cost	0%**
Mental Health – Outpatient (limited to 30 visits for regular treatment and 3 visits for crisis intervention)	10%	10%	10%
Inpatient Detoxification (limited to 30 days combined with inpatient mental health benefit)	\$500.00	No Cost	0%**
Durable Medical Equipment			
Diabetic Equipment and Supplies	No Cost \$ 15.00/item	No Cost \$ 10.00/item	20% 20%
Prosthetic and Orthotic Devices			
Such as prosthetic limbs, artificial eyes and external breast prostheses	No Cost	No Cost	20%
Deductibles			
Individual per calendar year	None	None	\$1,000.00
Family per calendar year	None	None	\$2,000.00
Maximum Out-of-Pocket Costs			
Individual per calendar year	\$1,500.00	None	\$3,000.00
Family per calendar year	\$3,000.00	None	\$5,000.00
Lifetime Maximum	None	None	\$500,000.00

*After the deductible is paid, the coinsurance payable is based on the usual, customary, and reasonable fee or a comparable fee schedule. After deductible and coinsurance requirements are met, your plan will pay 100% of the usual, customary and reasonable fee or 100% of a comparable fee schedule for services covered under the plan. You are always responsible for fees exceeding the usual, customary and reasonable fee or comparable fee schedule.

** not subject to deductible

Exclusions

The contracts contain exclusions such as coverage for unauthorized or unnecessary medical procedures, and experimental treatments. Please see your contract and member handbook for additional information.