

MEDICAL BENEFITS	PREFERRED PROVIDERS	NON-PREFERRED & EXTENDED PROVIDERS
Annual Deductible PCY (choose one) (Family is 3x the individual deductible)*	Individual: \$1,500 / \$2,500 / \$5,000 / \$7,500	2x individual deductible
Coinsurance ¹ (what you pay)	25%	50%
Annual Coinsurance Maximum (family = 2x individual)	\$9,000	Unlimited
Out-of-Pocket Maximum	Annual deductible + coinsurance maximum	
Office Visit Cost Share ²	No deductible applies on first 6 visits (\$25 copay only) [†]	Deductible applies first, then you pay 50%
Lifetime Maximum	\$2,000,000	
COVERED SERVICES	PREFERRED PROVIDERS	NON-PREFERRED & EXTENDED PROVIDERS
PREVENTIVE CARE		
Preventive Care Exams (routine medical exam, sports physical and women's health exams/well baby) ²	No deductible applies on first 6 visits (\$25 copay only) [†]	Deductible applies first, then you pay 50%
Preventive Screenings (includes Pap smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)	Covered in full ³	
Immunizations		
PROFESSIONAL CARE		
Office Visit including Urgent Care ²	No deductible applies on first 6 visits (\$25 copay only) [†]	Deductible applies first, then you pay 50%
Other Outpatient and Inpatient Professional Services	Deductible applies first, then you pay 25%	
ALTERNATIVE CARE		
Spinal and Other Manipulations 12 visits PCY (visits shared with Acupuncture)	\$25 Copay per visit	Deductible applies first, then you pay 50%
Acupuncture 12 visits PCY (visits shared with Spinal and Other Manipulations)		
Naturopathy ²		
DIAGNOSTIC SERVICES		
Outpatient Diagnostic Imaging and Lab Services	Deductible applies first, then you pay 25% (\$1,500 Deductible Plan: no deductible applies)	Deductible applies first, then you pay 50%
Mammography	Covered in full ³	
PHARMACY		
Retail Pharmacy (30-day supply)	\$20 Generics only	Preferred cost share + 40%
Mail Service Pharmacy (90-day supply)	\$50 Generics only	
EMERGENCY CARE		
Emergency Room Care (copay waived if direct admit to an inpatient facility)	\$100 Copay per visit; Deductible applies first, then you pay 25%	
Ambulance Transportation Air (unlimited); Ground (\$5,000 PCY limit)	Deductible applies first, then you pay 25%	
FACILITY CARE		
Inpatient Facility Care	Deductible applies first, then you pay 25%	Deductible applies first, then you pay 50%
Outpatient Facility Care		
Skilled Nursing Facility 45 days PCY; includes room and board, ancillaries and professional fees		
MATERNITY		
Maternity Care	Deductible applies first, then you pay 25%	Deductible applies first, then you pay 50%
VISION CARE		
Routine Vision Exam	Not covered	
Vision Hardware	Not covered	
OTHER SERVICES		
Supplies, Equipment and Prosthetics \$5,000 PCY	Deductible applies first, then you pay 25%	Deductible applies first, then you pay 50%
Home Health Care 130 visits PCY		
Hospice Care Inpatient: 10 days, Respite: 240 hours per 6 months lifetime maximum		
Rehabilitation (includes Physical, Occupational & Speech Therapy, Cardiac & Pulmonary Rehab; & Chronic Pain) Outpatient: 20 visits PCY; Inpatient: 8 days PCY		
Transplants (Organ & Bone Marrow) 12-month waiting period; \$250,000 Lifetime Benefit		
Alcohol Dependency Treatment		
	This optional benefit is available at an additional cost. It is limited to \$4,500 in any 24 consecutive months	

Deductible, coinsurance and copay represent what you pay. All coinsurance amounts are based on maximum allowable amounts. Benefits apply after calendar year deductible is met, unless otherwise noted as "no deductible," "copay," or "covered in full."

PCY= Per Calendar Year

- * Family = Individual plus one or more family members
- † Subsequent visits subject to deductible and 25%
- ¹ All coinsurance amounts are the member's percentage of maximum allowable amounts after deductible
- ² Office visits, preventive exams and naturopathy are shared
- ³ Benefits provided at 100% of maximum allowable amounts; not subject to deductible or coinsurance

This is only a summary of major benefits. It is not a contract.