

MEDICAL BENEFITS	PREFERRED PROVIDERS	NON-PREFERRED & EXTENDED PROVIDERS
Annual Deductible PCY (choose one) (Family is 3x the individual deductible)*	Individual: \$500 / \$1,000 / \$2,500 / \$5,000	2x individual deductible
Coinsurance ¹ (what you pay)	20%	50%
Annual Coinsurance Maximum (family = 2x individual)	\$7,500	Unlimited
Out-of-Pocket Maximum	Annual deductible + coinsurance maximum	
Office Visit Cost Share	\$20 Copay per visit	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)	\$20 Copay per visit	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 ²	
Immunizations		
PROFESSIONAL CARE		
Office Visit including Urgent Care	\$20 Copay per visit	Deductible applies first, then you pay 50%
Other Outpatient and Inpatient Professional Services	Deductible applies first, then you pay 20%	
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		
DIAGNOSTIC SERVICES		
Outpatient Diagnostic Imaging and Lab Services	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Mammography	Covered in full ²	
PHARMACY		
Retail Pharmacy (30-day supply)	\$20 Generics; 50% Brand	Preferred cost share + 40%
Mail Service Pharmacy (90-day supply)	\$50 Generics; 45% Brand	
EMERGENCY CARE		
Emergency Room Care (copay waived if direct admit to an inpatient facility)	\$100 Copay per visit; Deductible applies first, then you pay 20%	
Ambulance Transportation Air (unlimited); Ground (\$5,000 PCY limit)	Deductible applies first, then you pay 20%	
FACILITY CARE		
Inpatient Facility Care	Deductible applies first, then you pay 20%	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 20%	Deductible applies first, then you pay 50%
VISION CARE		
Routine Vision Exam (one exam per 2 calendar years)	Covered in full ²	
Vision Hardware (per 2 calendar years)	\$200 for frames, lenses and contact lenses	
OTHER SERVICES		
Supplies, Equipment and Prosthetics \$5,000 PCY	Deductible applies first, then you pay 20%	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		
Accident Benefit \$1,000 PCY	First \$1,000 is covered in full ² PCY; then paid as any other illness subject to deductible/coinsurance	
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
- ¹ All coinsurance amounts are the member's percentage of maximum allowable amounts after deductible
- ² 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.