

Please read Insurer Descriptions and Focus Provider Directories before making benefit plan selections.

BENEFIT CHOICES	IN NETWORK
<b><u>FINANCIAL</u></b>	
Network Copay	\$40 Copay
Dependant Children/Student Copay	\$0
<b>Annual Deductible Out of Network (Individual/Family)</b>	NA
Out of Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
<b>Annual Deductible In-Network (Individual/Family)</b>	\$2000/\$6000
In-Network Coinsurance/Coinsurance Max	80% / \$3000/\$9000
Out of Pocket Maximum	\$5000/\$15000
Lifetime Maximum Benefit	Unlimited
Max.Age for Dependent Children/Full-time Students	19/25
<b><u>PRESCRIPTION DRUG CARD BENEFITS</u></b>	
Generic/Name Brand/Non-formulary	\$50 Deductible \$0/\$30/\$50 \$1000 Retail Max
<b><u>ADULT &amp; CHILDREN'S PREVENTIVE CARE</u></b>	
Preventative: Well Baby, Well Child, Immunizations, Mammograms, Pap Tests, Annual Physical Exam	Covered in full Covered in full
<b><u>Care Rendered Outside a Hospital Setting</u></b>	
Primary Physician Office Visits	\$40 Copay /\$0 for Dep. Child/students
Specialist Office Visits	\$40 Copay /\$0 for Dep. Child/students
Laboratory Services	\$40 Copay /\$0 for Dep. Child/students
Radiology	\$40 Copay /\$0 for Dep. Child/students
<b><u>HOSPITAL CARE</u></b>	
Inpatient Facility Services	Deductible and Coinsurance
Out Patient Facility Service (Ambulatory Surgery)	Deductible and Coinsurance
In-Patient Physician and Surgeon Services	Deductible and Coinsurance
Out-Patient Physician and Surgeon Services	Deductible and Coinsurance
Semi-Private Room and Board	Deductible and Coinsurance
All Drugs and Medications	Deductible and Coinsurance
<b><u>EMERGENCY CARE</u></b>	
Emergency Room Copay	\$100 Copay
Emergency Room Professional Services	Up to 100% at the 90th %ile of HIAA
Ambulance Services when necessary	Deductible and Coinsurance
<b><u>MATERNITY CARE</u></b>	
Prenatal and Post-Natal Care	Covered in Full
Hospital Service	Deductible and Coinsurance
<b><u>MENTAL HEALTH CARE</u></b>	
Outpatient Visits/ 30 vistic Cal yr	\$40 Copay /\$0 for Dep. Child/students
Inpatient Care/ 30 Days Cal yr	Deductible and Coinsurance
<b><u>SUBSTANCE ABUSE</u></b>	
Inpatient Detox./ 7 Days Cal yr	Deductible and Coinsurance
Inpatient Rehab. / 30 Days Cal yr -60 days lifetime	Deductible and Coinsurance
Outpatient Visits/ 30 visits Cal yr	\$40 Copay /\$0 for Dep. Child/students
<b><u>ALTERNATIVE CARE SERVICES</u></b>	
Skilled Nursing Facility/ 60 Days Cal yr	Deductible and Coinsurance
Home Health Care 200 Visits Cal yr	20% Coinsurance (deductible waived)
Hospice/ 210 Days	Deductible and Coinsurance
<b><u>SHORT-TERM THERAPY</u></b>	
Physical Therapy, Occupational/ 30 visits Cal yr	\$40 Copay /\$0 for Dep. Child/students
Speech Therapy/ 10 Visits	\$40 Copay /\$0 for Dep. Child/students
<b><u>CHIROPRACTIC CARE</u></b>	
	\$40 Copay /\$0 for Dep. Child/students
<b><u>DURABLE MED. EQUIP/PROSTHETICS \$10,000 Cal yr</u></b>	
	Deductible and Coinsurance
<b><u>VISION</u></b>	
	\$10 Copay for an eye exam every 24 months
	\$20 Copay for glasses or contacts every 24 months for dependents 19 and under
<b><u>DENTAL</u></b>	
	NA

NOTE: This is a brief summary of benefits and should only be used as a guide. You must refer to the selected insurer's subscriber agreement for a complete description of requirements for coverage, covered services, limitations and exclusions.