

BENEFIT CHOICES	IN NETWORK
FINANCIAL	
Network Copay	\$40 Copay
Dependant Child/Student Copay	\$0 Copay
Annual Deductible Out of Network (Individual/Family)	NA
Out of Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
Annual Deductible In-Network (Individual/Family)	NA
In-Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
Lifetime Maximum Benefit	NA
Max.Age for Dependent Children/Full-time Students	19/25
PRESCRIPTION DRUG CARD BENEFITS	
Generic/Name Brand/Non-formulary	\$50 Deductible \$0/\$30/\$50 \$1000 Retail Max
ADULT & CHILDREN'S PREVENTIVE CARE	
Preventative: Well Baby, Well Child, Immunizations, Mammograms, Pap Tests, Annual Physical Exam	Covered in full
Care Rendered Outside a Hospital Setting	\$40 Copay/\$0 for Dep. Child/Student
Primary Physician Office Visits	\$40 Copay/\$0 for Dep. Child/Student/
Specialist Office Visits	\$40 Copay/\$0 for Dep. Child/Student
Laboratory Services	\$40 Copay/\$0 for Dep. Child/Student
Radiology	\$40 Copay/\$0 for Dep. Child/Student
HOSPITAL CARE	
Inpatient Facility Services	\$1000 Hospital Copay
Out Patient Facility Service (Ambulatory Surgery)	\$750 Ambulatory Copay
In-Patient Physician and Surgeon Services	Included in Hosp. Copay
Out-Patient Physician and Surgeon Services	Covered in Full
Semi-Private Room and Board	Included in Hosp. Copay
All Drugs and Medications	Included in Hosp. Copay
EMERGENCY CARE	
Emergency Room Copay	\$100 Copay
Emergency Room Professional Services	Covered in full
Ambulance Services when necessary	Covered up to UCR
MATERNITY CARE	
Prenatal and Post-Natal Care	Covered in Full
Hospital Service	\$1000 Hospital Copay
MENTAL HEALTH CARE	
Outpatient Visits/ 30 Visits Cal yr	\$40 Copay/\$0 for Dep. Child/Student
Inpatient Care/ 30 Days Cal yr	\$1000 Hospital Copay
SUBSTANCE ABUSE	
Inpatient Detox./ 7 Days Cal yr	\$1000 Hospital Copay
Inpatient Rehab./ 30 Days Cal yr -60 days lifetime	\$1000 Hospital Copay/ 30 Days Cal yr
Outpatient Visits/ 30 Visits Cal yr	Covered in full
ALTERNATIVE CARE SERVICES	
Skilled Nursing Facility/ 60 Visits Cal yr	\$1000 Hospital Copay
Home Health Care/ 200 Visits Cal yr	Covered in full
Hospice/ 210 Days	
SHORT-TERM THERAPY	
Physical Therapy, Occupational/ 30 Visits Cal yr	\$40 Copay/\$0 for Dep. Child/Student
Speech Therapy/ 10 Visits Cal yr	\$40 Copay/\$0 for Dep. Child/Student
CHIROPRACTIC CARE	\$40 Copay/\$0 for Dep. Child/Student
DURABLE MED. EQUIPMENT/PROSTHETICS	\$100 Deductible - \$10000 Cal. Yr. Max
VISION	\$10 Copay for an eye exam every 24 months
	\$20 Copay for glasses or contacts every 24 months for dependents 19 and under
DENTAL	
	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.