

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

BENEFIT CHOICES	IN NETWORK	OUT OF NETWORK
FINANCIAL		
Network Copay	\$30 Copay	Deductible and Coinsurance
Dependant child/Student Copay	\$0 Copay	Deductible and Coinsurance
Annual Deductible Out of Network (Individual/Family)	NA	\$2000/\$6000
Out of Network Coinsurance/Coinsurance Max	NA	70% / \$1500/\$4500
Out of Pocket Maximum	NA	\$3500/\$10500
Annual Deductible In-Network (Individual/Family)	\$1000/\$3000	NA
In-Network Coinsurance/Coinsurance Max	90% / \$500/\$1500	NA
Out of Pocket Maximum	\$1500/\$4500	NA
Lifetime Maximum Benefit	Unlimited	Unlimited/1,000,000 Annual
Max.Age for Dependent Children/Full-time Students	19/25	19/25
PRESCRIPTION DRUG CARD BENEFITS		
Generic/Name Brand/Non-formulary	\$50 Deductible \$0/\$30/\$50 \$1000 Retail Max	NA
ADULT & CHILDREN'S PREVENTIVE CARE		
Preventative: Well Baby, Well Child, Immunizations, Mammograms, Pap Tests, Annual Physical Exam	Covered in full	Deductible and Coinsurance
Care Rendered Outside a Hospital Setting		
Primary Physician Office Visits	\$30 Copay/ \$0 for Dep. child/student	Deductible and Coinsurance
Specialist Office Visits	\$30 Copay/ \$0 for Dep. child/student	Deductible and Coinsurance
Laboratory Services	\$30 Copay/ \$0 for Dep. child/student	Deductible and Coinsurance
Radiology	\$30 Copay/ \$0 for Dep. child/student	Deductible and Coinsurance
HOSPITAL CARE		
Inpatient Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
Out Patient Facility Service (Ambulatory Surgery)	Deductible and Coinsurance	Deductible and Coinsurance
In-Patient Physician and Surgeon Services	Deductible and Coinsurance	Deductible and Coinsurance
Out-Patient Physician and Surgeon Services	Deductible and Coinsurance	Deductible and Coinsurance
Semi-Private Room and Board	Deductible and Coinsurance	Deductible and Coinsurance
All Drugs and Medications	Deductible and Coinsurance	Deductible and Coinsurance
EMERGENCY CARE		
Emergency Room Copay	\$100 Copay	\$100 Copay
Emergency Room Professional Services	Deductible and Coinsurance	Up to 100% of HIAA at 90th %ile
Ambulance Services when necessary	Covered as out-of-network	Deductible and Coinsurance
MATERNITY CARE		
Prenatal and Post-Natal Care	Covered in Full	Deductible and Coinsurance
Hospital Service	Deductible and Coinsurance	Deductible and Coinsurance
MENTAL HEALTH CARE		
Outpatient Visits/ 30 visits Cal yr	\$30 Copay/ \$0 for Dep. child/student	Deductible and Coinsurance
Inpatient Care/ 30 Days Cal yr	Deductible and Coinsurance	Deductible and Coinsurance
SUBSTANCE ABUSE		
Inpatient Detox./ 7 Days Cal yr	Deductible and Coinsurance	NA
Inpatient Rehab. / 30 Days Cal yr -60 days lifetime	Deductible and Coinsurance	NA
Outpatient Visits/ 30 Visits Cal yr	\$30 Copay/ \$0 for Dep. child/student	NA
ALTERNATIVE CARE SERVICES		
Skilled Nursing Facility/ 60 Days Cal yr	Deductible and Coinsurance	NA
Home Health Care/ 200 Visits Cal yr	20% Coinsurance (deductible waived)	20% Coinsurance (deductible waived)
Hospice/ 210 Days	Deductible and Coinsurance	NA
SHORT-TERM THERAPY		
Physical Therapy, Occupational/ 30 Visits Cal yr	\$30 Copay/ \$0 for Dep. child/student	Deductible and Coinsurance
Speech Therapy/ 10 Visits Cal yr	\$30 Copay/ \$0 for Dep. child/student	Deductible and Coinsurance
CHIROPRACTIC CARE	\$30 Copay/ \$0 for Dep. child/students	Deductible and Coinsurance
DURABLE MED. EQUIPMENT/PROSTHETICS	Deductible and Coinsurance	Deductible and Coinsurance
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	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.