

PLUS PLAN

Benefit | Plan Maximum
 Unlimited Lifetime
 \$2,500,000 Annual



PHYSICIAN CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Office Visits:		
<i>Primary Care</i>	\$20 Copayment	70% after deductible
<i>Specialists</i>	\$40 Copayment	70% after deductible
<i>In-Hospital Visits</i>	100% after deductible	70% after deductible
<i>Surgery</i>	100% after deductible	70% after deductible
<i>Urgent Care</i>	\$40 Copayment	\$40 Copayment
<i>Spine Manipulation</i>	\$40 Copayment	70% after deductible
PREVENTIVE CARE		
Routine Well Care Includes:	\$0 Copayment	70% after deductible
<i>Pap Smear, Mammogram, Laboratory Blood Tests, Prostate Screening, Immunizations/Flu Shots, Colonoscopy</i>		
PRESCRIPTION DRUG BENEFIT		
Generic Drugs	\$10 Copayment	70% after deductible
Brand Name Drugs	\$25 Copayment Brand (<i>formulary</i>) \$50 Copayment Brand (<i>non-formulary</i>) \$2000 Annual Brand Maximum*	70% after deductible 70% after deductible
DIAGNOSTIC PROCEDURES		
<i>Diagnostic X-rays and laboratory services outside a physician's office</i>	100% after deductible	70% after deductible
HOSPITAL CARE		
<i>Room and Board</i>	100% after deductible	70% after deductible
<i>Emergency Room</i>	100% after deductible	100% after deductible
<i>Outpatient Surgery</i>	100% after deductible	70% after deductible
<i>Lab/X-ray</i>	100% after deductible	70% after deductible
<i>Outpatient Dialysis/Chemotherapy</i>	100% after deductible	70% after deductible
OTHER MEDICAL SERVICES		
<i>Skilled Nursing Facility</i> Limited 30 days per member per calendar year	100% after deductible	70% after deductible
<i>Hospice Care-Outpatient</i>	100% after deductible	70% after deductible
<i>Diabetes Supplies</i>	100% after deductible	70% after deductible
<i>Home Health Care</i> 60 visits per calendar year	100% after deductible	70% after deductible
<i>Ambulance Service</i>	100% after deductible	70% after deductible
<i>Occupational, Speech and Physical Therapy</i> 10 visits per calendar year per type of therapy	100% after deductible	70% after deductible
<i>Prosthetic</i>	100% after deductible	70% after deductible
<i>Organ Transplants</i>	100% after deductible	70% after deductible
DEDUCTIBLE AND COINSURANCE		
Deductible	\$5,000 Deductible	\$7,500 Deductible
Family Maximum	2 x Individual Deductible	2 x Individual Deductible
Coinsurance	100%	70%
MAXIMUM OUT-OF-POCKET		
Per Covered Person	\$5,000 Includes Deductible	\$10,000 Includes Deductible
Per Family Unit	\$10,000 Includes Deductible	\$20,000 Includes Deductible

- Annual maximum applies only to brand name drugs. There is no annual maximum for generic drugs.
 - Maximum out-of-pocket does not include copayments.