

# PREMIER PLAN

Benefit	Plan Maximum
	\$2,500,000 Lifetime
	\$500 Deductible



PHYSICIAN CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Office Visits:</b>		
<i>Primary Care</i>	\$20 Copayment	60% after deductible
<i>Specialists</i>	\$40 Copayment	60% after deductible
<i>In-Hospital Visits</i>	80% after deductible	60% after deductible
<i>Surgery</i>	80% after deductible	60% after deductible
<i>Urgent Care</i>	\$40 Copayment	60% after deductible
<i>Spine Manipulation</i>	\$40 Copayment	60% after deductible
<b>PREVENTIVE CARE</b>		
<b>Routine Well Care Includes:</b>	\$20 Copayment	60% after deductible
<i>Pap Smear, Mammogram, X-rays, Laboratory Blood Tests, Prostate Screening, Immunizations/Flu Shots</i>		
<b>PRESCRIPTION DRUG BENEFIT</b>		
<b>Generic Drugs</b>	\$10 Copayment	60% after deductible
<b>Brand Name Drugs</b>	\$25 Copayment Brand (formulary) \$50 Copayment Brand (non-formulary)	60% after deductible 60% after deductible
<b>DIAGNOSTIC PROCEDURES</b>		
<i>Diagnostic X-rays and laboratory services outside a physician's office</i>	80% after deductible	60% after deductible
<i>Colonoscopy</i>	\$200 Copayment	60% after deductible
<b>HOSPITAL CARE</b>		
<i>Room and Board, including Maternity</i>	80% after deductible	60% after deductible
<i>Emergency Room</i>	80% after deductible	60% after deductible
<i>Outpatient Surgery</i>	80% after deductible	60% after deductible
<i>Lab/X-ray</i>	80% after deductible	60% after deductible
<i>Outpatient Dialysis/Chemotherapy</i>	80% after deductible	60% after deductible
<b>OTHER MEDICAL SERVICES</b>		
<i>Skilled Nursing Facility</i> Limited 30 days per member per calendar year	80% after deductible	60% after deductible
<i>Hospice Care-Outpatient</i>	80% after deductible	60% after deductible
<i>Diabetes Supplies</i>	80% after deductible	60% after deductible
<i>Home Health Care</i> 60 visits per calendar year	80% after deductible	60% after deductible
<i>Ambulance Service</i>	\$200 Copayment	60% after deductible
<i>Occupational, Speech and Physical Therapy</i> 10 visits per calendar year per type of therapy	80% after deductible	60% after deductible
<i>Prosthetic</i>	80% after deductible	60% after deductible
<i>Organ Transplants</i>	80% after deductible	60% after deductible
<b>DEDUCTIBLE AND COINSURANCE</b>		
<b>Deductible</b>	\$500 Deductible	\$1,000 Deductible
<b>Family Maximum</b>	\$1,000 Deductible	\$2,000 Deductible
<b>Coinsurance</b>	80%	60%
<b>MAXIMUM OUT-OF-POCKET</b>		
<b>Per Covered Person</b>	\$2,500 Excludes Deductible	\$5,000 Excludes Deductible
<b>Per Family Unit</b>	\$5,000 Excludes Deductible	\$10,000 Excludes Deductible

- Maximum out-of-pocket does not include copayments.
- Preventive Care subject to \$500 annual maximum per person.