

# \$500 DEDUCTIBLE PREMIER PLAN



Benefit	\$2,500,000 Annual Maximum
	\$500 Annual Deductible
	Unlimited Lifetime

This table outlines **what you pay** for covered services after meeting the annual deductible, excluding copays and pharmacy expenses. Refer to the Summary Plan Description for a detailed list of the plan's benefits, limitations and exclusions.

	IN-NETWORK	OUT-OF-NETWORK
<b>DEDUCTIBLE &amp; COINSURANCE</b>		
<b>Annual Deductible</b>		
<i>Individual/Family</i>	\$500/\$1,000	\$1,000/\$2,000
<b>Coinsurance</b>	20%	40%
<b>ANNUAL COINSURANCE OUT-OF-POCKET MAXIMUM</b>		
<i>Individual/Family (excludes deductible, copays and pharmacy expenses)</i>	\$2,500/\$5,000	\$5,000/\$10,000
<b>PREVENTIVE CARE &amp; IMMUNIZATIONS</b>		
Covered as listed on the <i>Covered Preventive Care Services</i> chart in this Summary of Benefits.	0% no deductible	40% after deductible
<b>PHYSICIAN CARE</b>		
<b>Office Visits</b>		
Primary Care	\$20 copay	40% after deductible
Specialists	\$40 copay	40% after deductible
In-Hospital Visits	20% after deductible	40% after deductible
Surgery	20% after deductible	40% after deductible
Urgent Care	\$40 copay	\$40 copay
Spine Manipulation	\$40 copay	40% after deductible
<b>DIAGNOSTIC PROCEDURES</b>		
Diagnostic X-rays and laboratory services performed in a physician's office and billed by such physician or a free standing non-hospital billed facility only.	\$20 copay	40% after deductible
Colonoscopy (with diagnosis)	\$200 copay	40% after deductible
<b>HOSPITAL CARE</b>		
Room and Board (including maternity)	20% after deductible	40% after deductible
Emergency Room	20% after deductible	20% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Lab/X-ray	20% after deductible	40% after deductible
Outpatient Dialysis/Chemotherapy	20% after deductible	40% after deductible
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility <i>Limited 30 days per member per calendar year</i>	20% after deductible	40% after deductible
Hospice Care (outpatient)	20% after deductible	40% after deductible
Home Health Care <i>60 visits per calendar year</i>	20% after deductible	40% after deductible
Ambulance Service	\$200 copay	40% after deductible
Occupational, Speech and Physical Therapy <i>10 visits per calendar year per type of therapy</i>	20% after deductible	40% after deductible
Prosthetic	20% after deductible	40% after deductible
Organ Transplants	20% after deductible	40% after deductible

	IN-NETWORK	OUT-OF-NETWORK
<b>PRESCRIPTION DRUGS &amp; DIABETIC CARE SUPPLIES</b>  <i>When a brand name product is filled and a generic equivalent product is available, you will have to pay the difference in cost between the brand name and the generic, plus the generic copay or coinsurance.</i>		
<b>Retail Pharmacy</b> <i>Up to 30-day supply per copay. Up to 60-day supply for 2 copays or a 90-day supply for 3 copays. Day supply limits do not apply to diabetic care supplies.</i>		
Generic Drugs	\$10 copay	Not covered except in emergencies
Brand Name Drugs	\$25 copay	Not covered except in emergencies
Non-Formulary Drugs	\$50 copay	Not covered except in emergencies
Injectable Drugs ( <i>including insulin</i> )	25% coinsurance (\$60 maximum per 30-day supply)	Not covered except in emergencies
Diabetic Care Supplies ( <i>quantities shown only</i> ): 100 syringes 200 lancets 200 test strips	\$10 copay	Not covered
<b>Mail Order Pharmacy</b> <i>Up to 90-day supply per copay. Day supply limits do not apply to diabetic care supplies.</i>		
Generic Drugs	\$25 copay	Not covered
Brand Name Drugs	\$65 copay	Not covered
Non-Formulary Drugs	\$150 copay	Not covered
Injectable Drugs ( <i>including insulin</i> )	20% coinsurance (\$150 maximum per 90-day supply)	Not covered
Diabetic Care Supplies ( <i>quantities shown only</i> ): 300 syringes 600 lancets 600 test strips	\$25 copay	Not covered

**Pre-certification Penalty:** Certain procedures or medical care require pre-certification in order to qualify for full benefits. Failure to pre-qualify will result in \$500 penalty per service, procedure or confinement.

**Please Note:** this schedule applies as indicated in the Summary Plan Description. This schedule must be read in conjunction with the entire Summary Plan Description and has no meaning by itself.

**Covered Preventive Care Services**

See the table below for examples of covered preventive care services. For a complete listing, see your Summary Plan Description. Services covered once per member per coverage year unless otherwise noted. Any additional tests beyond the age and frequency limits listed below may be subject to deductible, coinsurance and/or copayments.

AGE RANGE	PREVENTIVE CARE SERVICE
Birth and over	<ul style="list-style-type: none"> <li>■ Immunizations (frequency and specific age guidelines in accordance with the Advisory Committee on Immunization Practices)</li> <li>■ Tuberculin skin testing</li> </ul>
Birth - 10 years	<ul style="list-style-type: none"> <li>■ Expanded newborn screen (blood)</li> <li>■ Evoked otoacoustic emissions (EOAE) once at birth</li> <li>■ Lead level screen</li> <li>■ Pediatric vision screen between birth and 5 years</li> </ul>
11 years and over	<ul style="list-style-type: none"> <li>■ Papanicolaou smear (female) until age 40</li> <li>■ Chlamydia, gonorrhea, and syphilis screen (male and female)</li> <li>■ Human papillomavirus (HPV) screen once every 3 years</li> <li>■ Human immunodeficiency virus (HIV) screen</li> </ul>
Beginning at age 20	<ul style="list-style-type: none"> <li>■ Lipid panel once every 5 years</li> </ul>
Beginning at age 40	<ul style="list-style-type: none"> <li>■ Mammogram (female)</li> <li>■ Breast cancer screen (female)</li> <li>■ Papanicolaou smear (female) once every 3 years</li> </ul>
Beginning at age 45	<ul style="list-style-type: none"> <li>■ Glucose screen once every 3 years</li> <li>■ Osteoporosis screen one time only (female)</li> </ul>
Beginning at age 50	<ul style="list-style-type: none"> <li>■ Prostate specific antigen (PSA) test (male)</li> <li>■ Colorectal cancer screen options (one of the following):               <ul style="list-style-type: none"> <li>• Fecal occult blood test once per member per coverage year (series of three) with flexible sigmoidoscopy every 5 years</li> <li>• Barium enema and flexible sigmoidoscopy every 5 years</li> <li>• CT Colonography every 5 years</li> <li>• Colonoscopy once every 10 years</li> </ul> </li> </ul>
Beginning at age 60	<ul style="list-style-type: none"> <li>■ Osteoporosis screen (female)</li> </ul>
Between age 65-75	<ul style="list-style-type: none"> <li>■ Abdominal aneurysm screen one time only (male)</li> </ul>

