

Effective Date 1/1/2009**Health Plan** Options**Ref** RQ-6812

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please contact our Sales or Customer Service Departments or refer to the plan contract.

Benefits	Inside Network	Outside Network
Plan deductible (PCY) - per calendar year	Individual deductible: \$100 Family deductible: \$200	Individual deductible: \$200 Family deductible: \$400
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 70%, you pay 30%
Pre-existing condition (PEC) waiting period	No PEC	Same as in-network
Out-of-pocket limit	Individual out-of-pocket limit: \$1000 Family out-of-pocket limit: \$2000	Individual out-of-pocket limit: \$2875 Family out-of-pocket limit: \$5750
Lifetime Maximum	\$2 million	Shared with in-network maximum
Outpatient Services (Office visits - OV)	No Copay, deductible and coinsurance apply	No Copay, deductible and coinsurance apply
Hospital services	Inpatient services: Deductible and coinsurance apply Outpatient surgery: No Copay, deductible and coinsurance apply	Inpatient services: Deductible and coinsurance apply Outpatient surgery: No Copay, deductible and coinsurance apply
Prescription drugs	Formulary generic/formulary brand \$15/\$30 copay	Formulary generic/formulary brand \$20/\$35 copay
Prescription mail order	2 x prescription cost share per 90 day supply	Not covered
Acupuncture	Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan No Copay, deductible and coinsurance apply	No Copay, deductible and coinsurance apply
Ambulance Services	80/20% coinsurance	Same as in-network
Chemical Dependency	\$14,500 per 24 months Outpatient: No Copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Benefit limits shared with in-network Outpatient: No Copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Devices, equipment and supplies (DME prosthetics)	20% coinsurance	Benefits and limits shared with in-network
Diagnostic lab and X-ray Services (outpatient)	Deductible and coinsurance apply	Deductible and coinsurance apply
Emergency Services (copay waived if admitted)	\$75 ER copay Deductible and coinsurance apply	\$125 ER deductible Plan deductible and coinsurance apply
Growth hormone	12 month wait, deductible and coinsurance apply	Same as in-network Deductible and coinsurance apply
Hearing exams (Routine)	No Copay, deductible and coinsurance apply	No Copay, deductible and coinsurance apply
Hearing hardware	\$400 per ear every 36 mos	Benefit shared with in-network
Home health	Covered in full. No visit limit.	No visit limit Deductible and coinsurance apply
Infertility services	50% diagnostic services & drugs, deductible and coinsurance apply	Shared with in-network
Manipulative therapy	Self-referred up to 20 visits PCY; additional visits when approved by plan No Copay, deductible and coinsurance apply	20 visit limit No Copay, deductible and coinsurance apply
Maternity services	Outpatient: No Copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Outpatient: No Copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Mental Health	Outpatient: 20 visits PCY No Copay, deductible and coinsurance apply Inpatient: 12 days PCY Deductible and coinsurance apply	Outpatient: Visit limits shared with in-network No Copay, deductible and coinsurance apply Inpatient: Visit limits shared with in-network Deductible and coinsurance apply

Naturopathy	Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan No Copay, deductible and coinsurance apply	No Copay, deductible and coinsurance apply
Obesity-related surgery (bariatric) When medically necessary and authorized lifetime max	Covered at cost shares	Not covered
Organ transplants Donor search & harvest rolls to lifetime max	\$250,000 lifetime max; includes donor search & harvest of \$50,000; waive 6 month wait Outpatient: No Copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Benefit limit shared with in-network Outpatient: No Copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full	\$150 per person; \$300 per family PCY
Rehabilitation services (Occupational, speech, physical-including massage) Rehab visits are a total of combined therapy visits PCY	Outpatient: 60 visits PCY No Copay, deductible and coinsurance apply Inpatient: 60 days PCY Deductible and coinsurance apply	Outpatient: Visit limits shared with in-network No Copay, deductible and coinsurance apply Inpatient: Day limits shared with in-network Deductible and coinsurance apply
Skilled nursing facility (PCY)	Up to 60 days, deductible and coinsurance apply	Days shared with in-network, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	No Copay, deductible and coinsurance apply	No Copay, deductible and coinsurance apply
Temporomandibular Joint (TMJ) Services	\$1,000 PCY; \$5,000 lifetime max Outpatient: No Copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Shared with in-network Outpatient: No Copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Tobacco Cessation See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full	Not Covered
Vision care Routine vision exam (1 visit every 12 months) No limit for medically necessary eye visits	No Copay, deductible and coinsurance waived	Covered at \$50 of usual, customary and reasonable charges
Optical Hardware Lenses, including contact lenses, and frames	\$165 per 24 months Not subject to deductible and coinsurance	\$165 per 24 months Not subject to deductible and coinsurance

