

<i>Type of Service</i>	<i>Description of Service</i>	<i>What Subscribers Pay Participating Provider</i>	<i>What Subscribers Pay Non-Participating Provider</i>
Annual Deductible	The amount that a subscriber must pay for covered services except for preventive care services before the program will cover those services at the copayment or coinsurance amount in one calendar year	\$1,500 per subscriber	\$3,000 per subscriber; does not count toward in-network deductible
Annual Deductible – Brand Name Prescription Drugs	The amount that a subscriber must pay for brand-name drugs before the program will cover those drugs at the copayment or coinsurance amount in one calendar year.	\$500 per subscriber	\$500 per subscriber; does not count toward in-network deductible
Copayment/Coinsurance	Subscriber's amount due and payable to the provider of care		See Below
Annual Maximum Copayment/	Subscriber's annual maximum copayment/coinsurance limit when using participating providers in one calendar year	\$2,500 per subscriber	No annual maximum copayment/coinsurance limit for non-participating providers. Subscribers pay unlimited coinsurance
Coinsurance Limit	<ul style="list-style-type: none"> The annual maximum copayment/coinsurance includes the \$1,500 annual deductible and the \$500 annual deductible for brand-name drugs If nonparticipating providers are used, billed charges which exceed the customary and reasonable charges are the subscriber's responsibility and do not apply to the annual maximum copayment/coinsurance limit 		
Annual Benefit Maximum	There is no annual benefit maximum in this program	None	None
Lifetime Benefit Maximum	There is no lifetime benefit maximum in this program	None	None
Preventive Care Services**	Preventive Services Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women, Human Papillomavirus (HPV) screening test, Ovarian and Cervical Cancer Screening, Cytology Examinations, Family Planning Services, Health Education Services, Periodic Health Examinations and Laboratory Services in connection with them, Hearing and Vision Exams for Children, Newborn Blood Tests, Prenatal Care (care during pregnancy), Prostate Exams for Men, Sexually Transmitted Infections (STI) tests, Human Immunodeficiency Virus (HIV) Testing, Well-Baby and Well-Child Visits, Certain Immunizations for children and adults, and Disease Management Programs	No Charge	50% of customary and reasonable charges and any in excess
Hospital Services	Inpatient medical services (semi-private room)	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
	Outpatient services; ambulatory surgical centers	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Physician Office Visits	Services of a physician for medically necessary services	\$25 copayment per visit	50% of customary and reasonable charges and any in excess
Diagnostic X-ray and Lab Services**	Outpatient diagnostic X-ray and laboratory services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Prescription Drugs	<ul style="list-style-type: none"> Maximum 30-day supply per prescription when filled at a participating pharmacy 90-day supply for mail order 	\$5 for generic drugs After the annual \$500 brand-name deductible is met: <ul style="list-style-type: none"> \$15 for formulary brand-name \$30 for non-formulary brand-name drugs and specialty drugs (need pre-authorization for specialty) Same copayments for mail order	Full cost of drugs at non-participating pharmacy; program reimburses subscriber 50% of generic and brand name prescription drug fee schedule

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Durable Medical Equipment and Supplies	Must be certified by a physician and required for care of an illness or injury	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Pregnancy** and Maternity Care	<ul style="list-style-type: none"> Inpatient normal delivery and complications of pregnancy Prenatal ** Postnatal 	15% of negotiated fee rate No charge 15% of negotiated fee rate	<ul style="list-style-type: none"> 50% of customary and reasonable charges and any in excess 50% of customary and reasonable charges and any in excess 50% of customary and reasonable charges and any in excess
Ambulance Services	Ground or air ambulance to or from a hospital for medically necessary services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Emergency Health Care Services*	Initial treatment of an acute serious illness or accidental injury. Includes hospital, professional, and supplies	15% of negotiated fee rate	50% of customary and reasonable charges or billed charges, whichever is less plus any charges in excess of customary and reasonable for the first 48 hours
Mental Health Care Services*	<ul style="list-style-type: none"> Inpatient basic mental health care services 10 days each calendar year Outpatient basic mental health care services 15 visits each calendar year * Unlimited inpatient days and outpatient visits for Severe Mental Illnesses	15% of negotiated fee rate and all costs for stays over 10 days 15% of negotiated fee rate for 15 visits per year and all costs for over 15 visits	<ul style="list-style-type: none"> 50% of customary and reasonable charges and any in excess and all costs for stays over 10 days 50% of customary and reasonable charges and any in excess and all costs over 15 visits
Alcohol and Substance Abuse Treatment*	<ul style="list-style-type: none"> Inpatient: As medically appropriate to remove toxic substances from the system Outpatient: 20 visits per benefit year (the number of visits may be increased in a benefit year if outpatient services are determined medically necessary) 	15% of negotiated fee rate 15% of negotiated fee rate for 20 visits per year and all costs for over 20 visits unless additional visits are determined medically necessary	<ul style="list-style-type: none"> 50% of customary and reasonable charges and any in excess 50% of customary and reasonable charges and any in excess and all costs over 20 visits
Home Health Care	Home health services through a home health agency or visiting nurse association	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Hospice	Hospice care for subscribers who are not expected to live for more than 12 months	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Skilled Nursing Facilities	Skilled nursing care Covered when determined to be a medically appropriate more cost-effective alternative plan of treatment	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Infusion Therapy*	Therapeutic use of drugs, or other substances ordered by a physician and administered by a qualified provider	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess for all infusion therapy related administrative, professional, and drugs
Physical/Occupational/ Speech Therapy	Services of physical therapists, occupational therapists, and speech therapists as medically appropriate on an outpatient basis	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess