

		PLAN A (PPO PLAN)	
		IN-NETWORK	OUT-OF-NETWORK
MAJOR MEDICAL			
Employee Deductible (Ded)		N/A	\$10,000 / Individual \$30,000 / Family
Coinsurance (MM)		100%	50%
Out-Of-Pocket Maximum (Excluding Deductible)		N/A	\$10,000 Individual \$30,000 Family
Lifetime Maximum Per Family Member		Unlimited	
PHYSICIAN'S OFFICE VISITS		100%; \$25 Co-Pay	50%
SPECIALIST OFFICE VISITS		100%; \$35 Co-Pay	50%
PRESCRIPTION DRUG CARD			
Retail Co-Pay		\$20 Generic \$30 Brand	
30 Day Supply		\$50 Preferred Brand \$40 Generic	
Mail Order Co-Pay		\$60 Brand \$100 Preferred Brand	
90 Day Supply			
AMBULATORY SURGERY		100%; after \$125 Co-pay	50%
All services performed in an In-Network Hospital will be covered as an In-Network claim (i.e. Anesthesia, Pathology & Radiology)			
HOSPITAL BENEFITS			
In-Patient		100%; after \$500 Co-pay	50%; after \$500 Co-pay
Out-Patient		100%	50%
Emergency Room (Medical Emergency)		100%; \$50 Co-pay (Waived if Admitted)	50%
SURGICAL BENEFITS			
In-Patient		100%; after \$500 Co-pay	50%
Out-Patient		100%	50%
DIAGNOSTIC X-RAY AND LABORATORY SERVICES		100%	50%
WELLNESS/PREVENTIVE (Routine Care)			
Physical Examinations		100%; after \$25 Co-pay	50%
Well Child Care (upto age 18) (Including Immunizations)		100%	50%
MENTAL/NERVOUS AND SUBSTANCE ABUSE			
Mental/Nervous:			
In-Patient		100%; after \$500 Co-pay	50%
10 Days Cal. Yr. Max.			
Out-Patient		100%; after \$25 Co-pay	50%
20 visits per Cal. Yr.			
Substance Abuse:			
In-Patient		100%; after \$500 Co-pay	50%
10 Days Cal. Yr. Max.			
Out-Patient		100%; after \$25 Co-pay	50%
20 Visits Cal. Yr. Max.			
ADDITIONAL MEDICAL BENEFITS			
Physical Therapy		100%; after \$25 Co-pay	50%
90 Days/Visits per Cal. Year			
Occupational Speech Therapy		100%; after \$25 Co-pay	50%
20 Visits per Cal. Year			
Chiropractic Services		100%; after \$35 Co-pay	50%
60 Visits per Cal. Year			
Pre-Admission Testing		100%; after \$25 Co-pay	50%
Second Surgical Opinion (As described in plan document)		100%	100%
Home Health Care (PreCertification Required)		100%; after \$500 Co-pay	50%
120 Visits Cal Yr. Max.			
Skilled Nursing Facility		50%	50%
\$10,000 Cal. Yr. Max			
Hospice		100%; after \$500 Co-pay	50%
Lifetime Maximum \$5,000			
Birth Center		100%	50%
Ambulance		100%	50%
Medical Supplies and Durable Equipment		100%	50%
FAMILY PLANNING			
Infertility Treatment		Member cost sharing is based on the type of service and the place of service where it is performed	
Voluntary Sterilization		Member cost sharing is based on the type of service and the place of service where it is performed	

The above summary is for illustrative purposes only. Please see Plan Booklet for a more detailed description.