

# Select Coverage 100% / 70%



Types of Coverage	PPO	Non-PPO*																																																																																																										
<b>Out-of-Pocket Expenses</b> <table border="1"> <thead> <tr> <th rowspan="2">Annual Deductible Option PPO/Non-PPO</th> <th rowspan="2">Number of Individual Deductibles</th> <th colspan="2">Copays</th> <th colspan="4">Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)</th> <th colspan="4">Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)</th> </tr> <tr> <th>Office Visit</th> <th>Urgent Care</th> <th>5K</th> <th>10K</th> <th>15K</th> <th>20K</th> <th>5K</th> <th>10K</th> <th>15K</th> <th>20K</th> </tr> </thead> <tbody> <tr> <td>\$100/\$250</td> <td>3</td> <td>\$15</td> <td>\$30</td> <td>\$100</td> <td>\$100</td> <td>\$100</td> <td>\$100</td> <td>\$1,750</td> <td>\$3,250</td> <td>\$4,750</td> <td>\$6,250</td> </tr> <tr> <td>\$250/\$500</td> <td>3</td> <td>\$20</td> <td>\$40</td> <td>\$250</td> <td>\$250</td> <td>\$250</td> <td>\$250</td> <td>\$2,000</td> <td>\$3,500</td> <td>\$5,000</td> <td>\$6,500</td> </tr> <tr> <td>\$500/\$1,000</td> <td>3</td> <td>\$25</td> <td>\$50</td> <td>\$500</td> <td>\$500</td> <td>\$500</td> <td>\$500</td> <td>\$2,500</td> <td>\$4,000</td> <td>\$5,500</td> <td>\$7,000</td> </tr> <tr> <td>\$750/\$1,500</td> <td>3</td> <td>\$25</td> <td>\$50</td> <td>\$750</td> <td>\$750</td> <td>\$750</td> <td>\$750</td> <td>\$3,000</td> <td>\$4,500</td> <td>\$6,000</td> <td>\$7,500</td> </tr> <tr> <td>\$1,000/\$2,500</td> <td>3</td> <td>\$30</td> <td>\$60</td> <td>\$1,000</td> <td>\$1,000</td> <td>\$1,000</td> <td>\$1,000</td> <td>\$4,000</td> <td>\$5,500</td> <td>\$7,000</td> <td>\$8,500</td> </tr> <tr> <td>\$1,500/\$3,000</td> <td>3</td> <td>\$40</td> <td>\$80</td> <td>\$1,500</td> <td>\$1,500</td> <td>\$1,500</td> <td>\$1,500</td> <td>\$4,500</td> <td>\$6,000</td> <td>\$7,500</td> <td>\$9,000</td> </tr> <tr> <td>\$2,500/\$5,000</td> <td>3</td> <td>ded./coin.</td> <td>ded./coin.</td> <td>\$2,500</td> <td>\$2,500</td> <td>\$2,500</td> <td>\$2,500</td> <td>\$6,500</td> <td>\$8,000</td> <td>\$9,500</td> <td>\$11,000</td> </tr> </tbody> </table> <p><i>Amounts applied toward the in-network deductible do not apply toward satisfaction of the out-of-network deductible and vice versa. Amounts applied toward the in-network maximum coinsurance limit are credited to the out-of-network maximum coinsurance limit and vice versa. The maximum calendar year coinsurance limit will never be more than two times the out-of-network deductible and coinsurance.</i></p>	Annual Deductible Option PPO/Non-PPO	Number of Individual Deductibles	Copays		Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)				Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)				Office Visit	Urgent Care	5K	10K	15K	20K	5K	10K	15K	20K	\$100/\$250	3	\$15	\$30	\$100	\$100	\$100	\$100	\$1,750	\$3,250	\$4,750	\$6,250	\$250/\$500	3	\$20	\$40	\$250	\$250	\$250	\$250	\$2,000	\$3,500	\$5,000	\$6,500	\$500/\$1,000	3	\$25	\$50	\$500	\$500	\$500	\$500	\$2,500	\$4,000	\$5,500	\$7,000	\$750/\$1,500	3	\$25	\$50	\$750	\$750	\$750	\$750	\$3,000	\$4,500	\$6,000	\$7,500	\$1,000/\$2,500	3	\$30	\$60	\$1,000	\$1,000	\$1,000	\$1,000	\$4,000	\$5,500	\$7,000	\$8,500	\$1,500/\$3,000	3	\$40	\$80	\$1,500	\$1,500	\$1,500	\$1,500	\$4,500	\$6,000	\$7,500	\$9,000	\$2,500/\$5,000	3	ded./coin.	ded./coin.	\$2,500	\$2,500	\$2,500	\$2,500	\$6,500	\$8,000	\$9,500	\$11,000	<p><i>Family Out-of-Pocket Maximum is three times (PPO) and two times (Non-PPO) the Individual Out-of-Pocket Maximum</i></p>	
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<b>Coinsurance</b>	100%	70%																																																																																																										
<b>Physician Visits</b> Includes office call charges plus diagnostic X-ray and laboratory charges on the same day related to the office visit.	100% after office visit copayment	70% of usual, customary, and reasonable (UCR) charges after deductible																																																																																																										
<b>Urgent Care Visits</b> Includes urgent care diagnostic X-ray and laboratory charges on the same day related to the urgent care visit.	100% after urgent care copayment	70% of UCR charges after deductible																																																																																																										
<b>Routine Examinations - \$500 Calendar Year Maximum</b> Includes physical examinations including immunizations, routine mammograms, pap tests, and hearing and vision examinations.	100% after office visit copayment per examination (For \$2,500/\$7,500 ded., routine benefit paid at 100% w/o copay)	70% of UCR charges after deductible																																																																																																										
<b>Physician/Clinic Other Services</b> Includes durable medical equipment, home health care, hospital visits, and other physician services. Maximums may apply to some services. See certificate for details.	100% after deductible	70% of UCR charges after deductible																																																																																																										
<b>Hospital Services</b> <b>Inpatient</b> care, including semi-private room or intensive care unit, operating room, and ancillary services. <b>Outpatient</b> hospital care, including all medically necessary services and supplies.	100% after deductible	70% of UCR charges after deductible																																																																																																										
<b>Emergency Room Care &amp; Facility Charges</b> Includes all services performed in the emergency room, including emergency room physician charges and facility.	100% after PPO deductible and \$100 copayment per visit (Note: Non-PPO services are also subject to UCR)																																																																																																											
<b>Prescription Drug Program</b> Prescription drug copayments do not apply toward out-of-pocket maximums. Up to a 90 day supply is allowed with mail order option. <i>If there is a tier 1 equivalent available for a tier 2 or non-preferred tier 3 drug, reimbursement will be made at the tier 1 equivalent rate.</i>	<b>Participating Pharmacy:</b> 100% of eligible expenses after \$10 copayment tier 1, \$25 copayment tier 2, \$50 copayment tier 3 <b>Mail Order Option:</b> 100% of eligible expenses after \$25 copayment tier 1, \$62.50 copayment tier 2, \$125 copayment tier 3 up to a 90 day supply																																																																																																											
<b>Mental Health, Alcohol and Drug Abuse Services</b> For groups with 51 or more employees** Maximum inpatient care up to \$7,000 in total eligible charges. Maximum outpatient care up to \$2,000 in total eligible charges. Maximum transitional treatment up to \$3,000 in total charges. Combined treatment arrangements cannot exceed \$7,000/calendar year.	100% after deductible for inpatient, outpatient, and transitional treatment benefits	70% of UCR after deductible for inpatient, outpatient, and transitional treatment benefits																																																																																																										
<b>Lifetime Maximum</b>	Combined benefits from all sources not to exceed \$5,000,000																																																																																																											

\* If provided at a PPO facility, services received from Non-PPO anesthesiologists, radiologists, and pathologists will be eligible for the PPO deductible and coinsurance levels, subject to UCR.  
 \*\* For groups with 51 or more employees, Mental Health, Alcohol and Drug Abuse Services per calendar year will be paid as follows: All benefits are subject to deductible and coinsurance; for inpatient treatment, benefits are payable for up to 10 days of confinement; for outpatient treatment, benefits are payable for up to 16 visits; for transitional treatment, benefits are payable for up to 12 visits.  
 All copayments are not credited to the deductible, out-of-pocket, or coinsurance. The emergency room facility charge copayment is waived if patient is admitted within 24 hours.

Optional Benefits	PPO	Non-PPO
<b>Prescription Drug Program</b> <i>If there is a tier 1 equivalent available for a preferred or non-preferred tier 3 drug, reimbursement will be made at the tier 1 equivalent rate.</i> <i>The copayment for the Prescription Drug Program is not credited to the deductible, out-of-pocket or coinsurance.</i>	<b>Participating Pharmacy:</b> 100% of eligible expenses after \$10 copayment tier 1, \$20 copayment tier 2, \$35 copayment tier 3 <b>Mail Order Option:</b> 100% of eligible expenses after \$25 copayment tier 1, \$50 copayment tier 2, \$87.50 copayment tier 3 up to a 90 day supply	
<b>Supplemental Accident Benefit</b> (Not available with \$2,500/\$5,000 deductible option)	\$500 per calendar year combined benefit from all sources	

All payment illustrations include payment amounts as indicated for covered benefits, subject to the terms and provisions of the Certificate.  
 The outlined benefits are intended to reflect the coverages provided in the Master Policy. A more detailed explanation of coverage is provided in the Certificate.