

Select Coverage 3000 70%/40%



Types of Coverage	PPO				Non-PPO*							
Out-of-Pocket Expenses	Individual Out-of-Pocket Maximum Options <i>(includes deductible and coinsurance)</i>				Individual Out-of-Pocket Maximum Options <i>(includes deductible and coinsurance)</i>							
Annual Deductible	Number of Individual	Copays		5K/10K	10K/20K	15K/30K	20K/40K	5K/10K	10K/20K	15K/30K	20K/40K	
PPO/Non-PPO Options	Deductibles	Office Visit	Urgent Care									
\$250/\$750	3	\$20	\$40	\$1,750	\$3,250	\$4,750	\$6,250	\$6,750	\$12,750	\$18,750	\$24,750	
\$500/\$1,500	3	\$25	\$50	\$2,000	\$3,500	\$5,000	\$6,500	\$7,500	\$13,500	\$19,500	\$25,500	
\$750/\$2,250	3	\$25	\$50	\$2,250	\$3,750	\$5,250	\$6,750	\$8,250	\$14,250	\$20,250	\$26,250	
\$1,000/\$3,000	3	\$30	\$60	\$2,500	\$4,000	\$5,500	\$7,000	\$9,000	\$15,000	\$21,000	\$27,000	
\$1,500/\$4,500	3	\$40	\$80	\$3,000	\$4,500	\$6,000	\$7,500	\$10,500	\$16,500	\$22,500	\$28,500	
\$2,500/\$7,500	3	ded./coin.	ded./coin.	\$4,000	\$5,500	\$7,000	\$8,500	\$13,500	\$19,500	\$25,500	\$31,500	
<i>Amounts applied toward the PPO deductible do not apply toward satisfaction of the non-PPO deductible and vice versa. Amounts applied toward the PPO out-of-pocket maximum are not credited to the non-PPO out-of-pocket maximum and vice versa.</i>				<i>Family Out-of-Pocket Maximum is <u>three times</u> the Individual Out-of-Pocket Maximum</i>								
Physician/Urgent Care Visits												
Physician Visits - including office call charges					100% after office visit copayment				40% of usual, customary, and reasonable (UCR) charges after deductible			
Urgent Care Visits					100% after urgent care copayment				40% of UCR charges after deductible			
Diagnostic Lab and X-ray - including charges that occur on the same day related to a physician visit or urgent care visit. <i>Physician and UC visits and diag. lab/x-ray services for \$2,500/\$7,500 ded. option are subject to ded./coin. The \$500 first-dollar coverage for diag. lab/x-ray and lab charges does not apply.</i>					100% up to \$500 per calendar year; deductible and coinsurance applies thereafter				40% of UCR charges after deductible			
Routine Examinations - \$500 Calendar Year Maximum 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)				Not covered: Immunizations, mammograms, and lab costs for pap tests are covered as specified in the Certificate			
Physician/Clinic Other Services Includes durable medical equipment, home health care, hospital visits, and other physician services. Maximums may apply to some services. See certificate for details.					70% after deductible				40% of UCR charges after deductible			
Chiropractic Visits - \$500 Calendar Year Maximum					100%				100% of UCR			
Hospital Services Inpatient care, including semi-private room or intensive care unit, operating room, and ancillary services. Outpatient hospital care, including all medically necessary services and supplies.					70% after deductible				40% of UCR charges after deductible			
Emergency Room Care & Facility Charges Includes all services performed in the emergency room, including emergency room physician charges and facility.					70% after PPO deductible and \$100 copayment per visit (Note: Non-PPO services are also subject to UCR)							
Prescription Drug Program 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>					Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$25 copayment tier 2, \$50 copayment tier 3 Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$62.50 copayment tier 2, \$125 copayment tier 3 up to a 90 day supply							
Mental Health, Alcohol and Drug Abuse Services For groups with 51-99 employees** For Indiana groups with 51-99 employees*** Combined lifetime maximum of \$25,000.					Inpatient and Outpatient charges including prescription drugs—benefits payable at 50% after deductible to a maximum payment of \$5,000 per calendar year				Inpatient and Outpatient charges including prescription drugs—benefits payable at 50% of UCR after deductible to a maximum payment of \$2,500 per calendar year			
Lifetime Maximum					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 51-99 employees, Mental Health, Alcohol and Drug Abuse Services per calendar year will be paid as follows: For PPO inpatient charges, benefits are payable at 50% after deductible up to 10 days of confinement; the benefits for PPO outpatient charges are payable at 50% after deductible up to 30 visits. For Non-PPO inpatient charges, benefits are payable at 50% after deductible up to 5 days of confinement; the benefits for Non-PPO outpatient charges are payable at 50% after deductible up to 15 visits.

*** For Indiana groups with 51-99 employees, the base plan will not include Mental Health benefits, however an optional package is available which includes Mental Health benefits covered on the same basis as any other covered expense. Alcohol and Drug Abuse Services will be paid at the 51-99 employee level as indicated in the above paragraph.

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.

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.

Optional Benefits	PPO	Non-PPO
Prescription Drug Program <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. The copayment for the Prescription Drug Program is not credited to the deductible, out-of-pocket or coinsurance.</i>	Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$20 copayment tier 2, \$35 copayment tier 3 Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$50 copayment tier 2, \$87.50 copayment tier 3 up to a 90 day supply	
Supplemental Accident Benefit	\$500	