



BENEFIT	PLAN 6 - C
MAJOR MEDICAL*	Deductible: \$250 Individual / \$750 Family Coinsurance: 80 / 20 Out Of Pocket Max: \$1,000 Per Person + Deductible
LIFETIME MAX PER PERSON	Effective 10/1/2010 there will no longer be a lifetime maximum.
DOCTOR VISITS	\$20 Copay (Copay not applied to deductible or out-of-pocket max.)
IMMUNIZATIONS	Certain age appropriate preventive care services will be covered without cost sharing at a contracted provider. *Major Medical
PREVENTIVE CARE FOR CHILDREN	Covered, as long as eligible. Certain age appropriate preventive care services will be covered without cost sharing at a contracted provider. *Major Medical
PREVENTIVE CARE FOR ADULTS	Certain age appropriate preventive care services will be covered without cost sharing at a contracted provider. *Major Medical
OUTPATIENT X-RAY & LAB	*Major Medical
RADIATION THERAPY, CHEMOTHERAPY & SURGERY	*Major Medical
DURABLE MEDICAL EQUIPMENT	*Major Medical
AMBULANCE-GROUND/AIR	*Major Medical
PHYSICAL THERAPY	*Major Medical (Copay, if applicable) Non-Par Providers limited to a combined maximum 13 visits per year, max \$25 per visit.

Page 2	PLAN 6 - C	
CHIROPRACTIC	*Major Medical (Copay, if applicable) Non-Par Providers limited to a combined maximum 13 visits per year, max \$25 per visit.	
ACUPUNCTURE	*Major Medical (Copay, if applicable) Maximum of 12 visits per calendar year	
HOSPITAL INPATIENT	*Major Medical Unlimited days; Semi private room	
HOSPITAL EMERGENCY ROOM	\$35 co-pay *Major Medical (Copay waived if admitted as in-patient)	
HOME HEALTH CARE	*Major Medical Limited to 100 visits per calendar year	
HOSPICE	100% of Covered Expense with a lifetime maximum of \$10,000	
PRESCRIPTION DRUGS (CO-PAYMENTS)	<u>Retail</u> \$7 Generic \$25 Preferred \$40 Non-Preferred (30-day supply)	<u>Mail Order</u> \$15 Generic \$60 Preferred \$90 Non-Preferred (90-day supply)

* **Major Medical** - Deductible and coinsurance apply.

****Explanation of Covered Expense:**

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following: **PPO Providers** - PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount. **Non-PPO Providers** - For non-emergency services, the scheduled amount. For emergency services, same as other health care providers. **Other Health Care Providers** (includes those not represented in the PPO provider network) - The customary & reasonable charge for professional services or the reasonable charge for institutional services. **When using Non-PPO & Other Health Care Providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible & percentage copay.** All percentages are based on payments to preferred hospitals, physicians and other network providers.

Mental Health Parity Effective October 1, 2010.

This summary is for comparison purposes only. Please refer to the actual benefit booklet for complete benefits.