

Deductible — \$500 single / \$1,000 family per calendar year  
Coinsurance — 20%  
Maximum out of pocket — \$1,500 single / \$2,000 family per  
Contract year  
Maximum Lifetime Benefit — \$250,000

*Physician Services*

Office visits	Covered at 80% after satisfying deductible
Inpatient visits	Covered at 80% after satisfying deductible
Surgery	Covered at 80% after Satisfying deductible
Allergy treatment	Covered at 80% after satisfying deductible

*Preventive Services (Partial listing of covered services)*

Routine physicals includes mammograms	Covered at 80% after satisfying deductible
Well child care (through age17) Includes pediatric immunizations	Covered in full
Adult immunizations	Covered at 80% after satisfying deductible

*Maternity Care*

Physician	Covered at 80% after satisfying deductible
Hospital	Covered at 80% after satisfying deductible

*Diagnostic Services*

Eye exam & Hearing exam	Covered at 80% after satisfying deductible
X-rays and lab	Covered at 80% after satisfying deductible
MRI and Cat Scans	\$50 copay up to \$150 maximum

*Infertility Services*

Not Covered

*Chiropractic Care*

Covered at 80% after satisfying deductible

*Podiatry*

Covered at 80% after satisfying deductible

*Transplants*

Limited to Kidney	Covered at 80% up to benefit maximum after satisfying deductible
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*Emergency Services*

Urgent care center	Covered at 80% after satisfying deductible
Hospital emergency room	Covered in full after \$75 copayment per visit
Ancillary emergency services	Covered at 80% after satisfying deductible

*Ambulance Service*

Ground and Air	Covered in full
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*Hospital and Surgery Center Services*

Rooms and facility charges	Covered at 80% after satisfying deductible
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*Oral Surgery*

Not Covered

*TMD / TMJ*

Covered up to benefit maximum after satisfying deductible

*Physical, Speech and Occupational Therapy*

Not Covered

*Inpatient Rehabilitative Medical Confinement*

Limited to 90 days per occurrence	Covered at 80% after satisfying deductible
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*Home Health Services*

Limited to 40 visits per Contract year	Covered at 80% after satisfying deductible
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*Licensed Skilled Nursing Facility*

Limited to 30 days of skilled care payable at the DHFS rate per benefit period	Covered at 80% after satisfying deductible
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*Outpatient Mental Health Care, Alcohol/ Drug Abuse Treatment*

Covered up to 20 visits after satisfying deductible; Transitional up to 15 full day treatments

*Prescription Drugs — Outpatient*

Not covered

*Insulin and Disposable Diabetic Supplies*

Limited to 30-day supply per item per prescription or refill	Covered in full after 25% copay. Deductible does not apply
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*Durable Medical Equipment*

Hearing aid	Not covered
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Other (includes Diabetic Durable Equipment) Lifetime maximum benefit for prosthetics and orthotics combined is \$30,000 per member	Covered in full after 25% copay and deductible
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All benefits are subject to limitations and exclusions as described in your Member Certificate and Schedule of Benefits. A complete listing of your specific Schedule of Benefits may be located on our website or be calling our Customer Service Department.