BUY UP PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $350 $700	 $1,500 $3,000
Co-insurance After Deductible	20%	50%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum Individual	 $4,000	 Unlimited
Family	$8,000	Unlimited
Physician Office Visits Primary Physician	 $25 copay	 50% co-insurance, after deductible
Specialist	$50 copay	50% co-insurance, after deductible
Preventive Care	No Charge	50% co-insurance, No Deductible
Allergy Testing and Injections	20% co-insurance, after deductible	50% co-insurance, after deductible
Infertility Counseling and Testing	20% co-insurance, after deductible	50% co-insurance, after deductible
Radiology (X-ray) and Laboratory Services Diagnostic	20% co-insurance, after deductible	50% co-insurance, after deductible
Routine Preventative Radiology and Laboratory Testing	No Charge	50% co-insurance, after deductible
Ambulance Emergent	 No Charge, after deductible	 No Charge, after deductible
Non-Emergent	20% co-insurance, after deductible	20% co-insurance, after deductible

BUY UP PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Emergency Care Hospital ER (copay waived if admitted)	$750 copay	$750 copay
Urgent Care Center	$25 copay	$25 copay
Hospital Daily Hospital Room and Board, Semi Private and other allowable expenses Inpatient Services	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient Services	20% co-insurance, after deductible	50% co-insurance, after deductible
Mental and Substance Abuse Inpatient Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible
Outpatient -Hospital	20% co-insurance, after deductible	50% co-insurance, after deductible
-Office	$50 copay	50% co-insurance, after deductible
Accidental Dental Treatment	20% co-insurance, after deductible	50% co-insurance, after deductible
Home Health Care	20% co-insurance, after deductible	50% co-insurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price.)	20% co-insurance, after deductible	50% co-insurance, after deductible
Respiratory Therapy	20% co-insurance, after deductible	50% co-insurance, after deductible
Physical Medicine Limited to 20 visits per calendar year.	$50 copay	50% co-insurance, after deductible

BUY UP PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Speech and Occupational Therapy Limited to 20 visits per calendar year.	$50 copay	50% co-insurance, after deductible
Other Therapies	20% co-insurance, after deductible	50% co-insurance, after deductible
Chiropractic Services Limited to 20 visits per calendar year.	$50 copay	50% co-insurance, after deductible
Skilled Nursing Facility Limited to 100 days per calendar year.	20% co-insurance, after deductible	50% co-insurance, after deductible
Private Duty Nursing	20% co-insurance, after deductible	50% co-insurance, after deductible
Hospice	20% co-insurance, after deductible	50% co-insurance, after deductible

PRESCRIPTION DRUG BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$10 copay	Not Covered
Brand Name Drugs	$35 copay	Not Covered
Non – Preferred Brand Name Drugs	$50 copay	Not Covered
Specialty Prescription Drugs	$100 copay	Not Covered
Mail Order 90-Day Supply		
Generic Drugs	$25.00 copay	Not Covered
Brand Name Drugs	$87.50 copay	Not Covered
Non – Preferred Brand Name Drugs	$125 copay	Not Covered
Specialty Prescription Drugs	$250 copay	Not Covered