

Benefit highlights

	COPAYMENT 25	COPAYMENT 40	COPAYMENT 50
FEATURES			
Individual plan annual deductible (subscriber only)	None		
Family plan annual deductible (individual/family)	None		
Individual plan annual out-of-pocket maximum (subscriber only)	\$2,500	\$3,000	\$3,500
Family plan annual out-of-pocket maximum (individual/family)	\$2,500/\$5,000	\$3,000/\$6,000	\$3,500/\$7,000
Lifetime benefit maximum	None		
BENEFITS			
Preventive care			
Immunizations	No charge		
Routine physical exam	\$25 copay	\$40 copay	\$50 copay
Well-child visit (0–23 months)	No charge	\$10 copay	\$15 copay
Well-woman visit	\$25 copay	\$40 copay	\$50 copay
Mammogram	\$10 copay		
Outpatient services (per visit or procedure)			
Primary care/Specialty office visit	\$25 copay	\$40 copay	\$50 copay
Most X-rays and lab tests	\$10 copay		
MRI, CT, and PET	\$50 copay		
Outpatient surgery	\$100 copay	\$200 copay	\$250 copay
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	\$200 copay per day	\$350 copay per day	\$500 copay per day
Maternity Coverage varies. Please consult the plan's <i>Membership Agreement</i> .			
Maternity care	Covered		
Emergency and urgent care			
Emergency Department visit (waived if admitted)	\$100 copay		\$150 copay
Urgent care visit	\$25 copay	\$40 copay	\$50 copay
Ambulance service	\$100 copay	\$200 copay	\$300 copay
Prescription drugs			
Plan pharmacy (up to a 30-day supply)	Generic: \$10 copay/Brand: \$35 copay		Not covered
Mail-order (up to a 100-day supply)	Generic: \$20 copay/Brand: \$70 copay		Not covered

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For more information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form* enclosed in this kit. Detailed information about your plan is included in the *Membership Agreement*, which will be mailed to you upon acceptance or upon request.

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