

Plan Options	Progressive \$300 ded 90/80/50 \$25	Progressive \$650 ded 100/80/80/50 \$25	Progressive \$1250 ded 80/80/50 \$30	Progressive \$2000 ded 80/80/50 \$35	Advance 500 \$500 ded 100/80/80/50 \$25	Advance 1000 \$1000 ded 100/80/80/50 \$25	HSA
Annual Deductible	\$300 Individual \$600 Family	\$650 Individual \$1300 Family	\$1,250 Individual \$2,500 Family	\$2000 Individual \$4000 Family	Individual \$500 Family \$1,500	Individual \$1,000 Family \$3,000	\$1,500 Individual \$3000 Family
Out-of-pocket Max.	\$2,500 Individual 2 x Family	\$2,500 Individual 2 x Family	\$5,000 Individual 2 x Family	\$5,000 Individual 2 x Family	\$2,500 Individual 7,500 Family	\$2,500 Individual 7,500 Family	\$5,000 Individual 2 x Family
PLAN BENEFITS							
Professional Services							
Provider Network	Preferred Par & Non Par	Preferred Par & Non Par	Preferred Par & Non Par	Preferred Par & Non Par	Preferred Par & Non Par	Preferred Par & Non Par	Preferred Par & Non Par
ER Copay	\$150, waived if admitted	\$150, waived if admitted	\$150, waived if admitted	\$150, waived if admitted	\$75, waived if admitted	\$75, waived if admitted	\$75, waived if admitted
Physician Office Visit	\$25 Copay 90% Professional 50% 80% Facility 50%	\$25 Copay *100% Professional 50% 80% Facility 50%	\$30 Copay 80% Professional 50% 80% Facility 50%	\$35 Copay 80% Professional 50% 80% Facility 50%	\$25 Copay 100% 50%	\$25 Copay 100% 50%	
*100% Professional when billed as Office Visit					80% 50%	80% 50%	80% 60%
	Deductible Waived	Deductible Waived	Deductible Waived	Deductible Waived	Deductible Waived	Deductible Waived	Deductible Applies
Preventive Care	\$25 Copay 90% Professional 50% 80% Facility 50%	\$25 Copay 80% Professional 50% 80% Facility 50%	\$30 Copay 80% Professional 50% 80% Facility 50%	\$35 Copay 80% Professional 50% 80% Facility 50%	\$25 Copay 100% 50%	\$25 Copay 100% 50%	80% 60%
	Deductible Waived \$500 maximum per year	Deductible Waived \$500 maximum per year	Deductible Waived \$500 maximum per year	Deductible Waived \$500 maximum per year	Deductible Waived Unlimited Maximum	Deductible Waived Unlimited Maximum	Deductible Waived \$300 maximum per year
Diagnostic Lab and X-ray					100% 50%	100% 50%	80% 60%
Outpatient (professional)	90% 50%	80% 50%	80% 50%	80% 50%	(not subject to the deductible) First \$500 per cal. year 80% 50%	(not subject to the deductible) First \$500 per cal. year 80% 50%	Deductible Applies
	Deductible Waived	Deductible Waived	Deductible Waived	Deductible Waived	(subject to the deductible) Charges above \$500 per cal. year	(subject to the deductible) Charges above \$500 per cal. year	
Inpatient (facility)	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 60%
	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies
Alternative Care	\$25 Copay	\$25 Copay	\$30 Copay	\$35 Copay	\$25 Copay	\$25 Copay	
Spinal Manipulations 12 manipulations per year	80% 50%	80% 50%	80% 50%	80% 50%			80% 60%
Acupuncture 12 visits per year	Deductible Waived 80% 50%	Deductible Waived 80% 50%	Deductible Waived 80% 50%	Deductible Waived 80% 50%	80% 50%	80% 50%	Deductible Applies
	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies	
Rehabilitation							80% 60%
Inpatient 15,000 per condition	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	Deductible Applies
Outpatient \$1,000 per year	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 60%
							Deductible Applies
Chemical Dependency							80% 60%
\$14,000 every 2 cal year	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	Deductible Applies
Mental & Nervous							80% 60%
Inpatient (facility) 8 days per year	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	Deductible Applies
Outpatient (professional) 12 visits per year	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 50%	80% 60%
							Deductible Applies
Lifetime Maximum							
\$20,000 annual reinstatement	\$2,000,000*	\$2,000,000*	\$2,000,000*	\$2,000,000*	\$2,000,000*	\$2,000,000*	\$2,000,000*
Prescription Drug Plans							
Retail (34 day supply)	10/\$20/\$40	10/\$25/\$50	10/(\$50 Brand copay) \$35/\$70	10/(\$50 Brand copay) \$20/\$40	MAC A		
Mail order (90 day supply)	\$20/\$40/\$80 Mail order	\$30/\$75/\$150 Mail order	\$30/\$105/\$210 Mail order	\$20/\$40/\$80 Mail order			

This is a brief summary of benefits. For complete details of benefits and exclusions, please refer to the actual plan booklet or contract. Should there be any discrepancy the contract will be the determining document on how benefits are paid.