

Copay Plans -- Benefit Highlights

	Copay Select SM	Copay Saver SM
Design Basics		
Network Type	Preferred Network Included	
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	\$500, \$1,000, \$1,500, \$2,500	\$2,500
Coinsurance (per covered person, per calendar year)	80/20 to \$10,000 then 100%	80/20 to \$15,000 then 100%
Lifetime Maximum Benefit (per covered person)	\$3 million	\$3 million
Initial Rate Guarantee (subject to benefit and address changes)	12 months	12 months
Coverage percentages below are effective AFTER deductibles have been met unless otherwise indicated.		
Inpatient Expense Benefits		
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	80%	80%
Other Covered Inpatient Services	80%	80%
Outpatient Expense Benefits		
Surgeon, Assistant Surgeon, and Facility Fees	80%	80%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	80%	80%
CAT Scans, MRIs	80%	80%
Outpatient X-ray and Lab (performed in the doctor's office or elsewhere)	80%	80% if performed within 14 days of surgery or confinement
Emergency Room Fees	80% -- additional \$100 Copay for illness if not admitted	80% -- additional \$500 Copay if not admitted
Other Covered Outpatient Expenses	80%	See page 10
Routine Health Benefits		
Doctor Office Visit	For history and exam: \$25 Copay, then 100% (not subject to deductible)	For history and exam: \$35 Copay, then 100% (maximum 2 visits per person, per year) Other services: Not Covered
Mammography, Pap Smear, and PSA Testing (not subject to the calendar year deductible)	For history and exam: \$25 Copay, then 100%	80%
Adult Preventive Care (age 19 or older)	For other services performed in or out of doctor's office, including, but not limited to, X-ray and Lab, subject to the deductible, then 80%	Not Covered
Well Child Care/Immunizations (ages 0-18)		Not Covered
Outpatient Prescription Drugs	Generic: \$15 Copay Name Brand: \$100 per person, calendar year deductible -- then \$30 Copay for preferred, \$60 Copay for non-preferred (If Generic is available, Name Brand reimbursed at Generic price)	Generic: \$15 Copay Name Brand: Not Covered
Optional Benefits	For a complete list, see page 8.	

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits unless you use a network. We recommend review of the more detailed plan information on pages 9-14.