

HEALTH INSURANCE-  
IN AND OUT OF NETWORK PLAN (POS)

Coverage	2004 Plan	
	In Network	Non-Network
Type plan	In Network	Non-Network
Deductible	Not Applicable	\$500/\$1000
Annual Out of Pocket Max (in addition to deductible)	Not Applicable	\$1500/\$3000
Maximum lifetime Benefit	Not Applicable	\$1,000,000
<b>Provider Office Visit</b>		After deductible you are responsible for.
Primary Physician	\$25 per visit	20% of eligible expenses
Specialist	\$25 per visit	20% of eligible expenses
Maternity care office visits	\$25 per pregnancy (first visit only)	20% of eligible expenses
<b>Medical Inpatient Hospital &amp; Related Services</b>		
Medical room & board/other patient services & supplies	\$250 copayment per admission	20% of eligible expenses
Physician services while hospitalized	No copayment	20% of eligible expenses
Maternity inpatient services	\$250 copayment per admission	20% of eligible expenses
Hospital & related services for mastectomy & postmastectomy care	\$250 copayment per admission	20% of eligible expenses
<b>Outpatient Services &amp; Supplies</b>		
Outpatient surgery	No copayment	20% of eligible expenses
Outpatient physician services	No copayment	20% of eligible expenses
Laboratory/diagnostic tests & procedures (except below)	No copayment	20% of eligible expenses
MRI's, CT Scan, PET Scan, Nuclear Medicine	No copayment	20% of eligible expenses
<b>Emergency Services</b>		
Emergency room services	\$150 per occurrence	Same as network
Emergency room prescriptions	See prescriptions	See prescription
Ambulance services	No copayment	20% of eligible expenses
Urgent care center	\$50 per visit	20% of eligible expenses
<b>Outpatient Mental Health Svcs</b>		
Individual therapy services	\$25 per visit	In network services only
Group therapy services	\$20 per visit	In network services only
<b>Inpatient Mental Health</b>		
Inpatient Services	\$250 per inpatient stay	In network services only
Physician services while hospitalized		In network services only
Treatment of medical complications		In network services only
<b>Outpatient Chemical Dependency Services</b>		
Individual therapy services	\$25 per visit	In network services only
Group therapy services	\$20 per visit	In network services only
Intensive rehabilitation		In network services only
<b>Miscellaneous Health Services</b>		
Home health care	No copayment	20% of eligible expenses
Physical, occupational & speech therapy limited to 20 visits per therapeutic type, per calendar year	\$25 per visit	20% of eligible expenses
Skilled nursing facility & rehabilitative care limited to 90 days per calendar year	No copayment	20% of eligible expenses
Non-emergency ground transportation	No copayment	20% of eligible expenses
Durable medical equipment & prosthetics	No copayment	20% of eligible expenses
Diabetic supplies & medication	Use RX benefit	20% of eligible expenses
Diabetic outpatient education	No copayment	20% of eligible expenses
Ostomy medical supplies	No copayment	20% of eligible expenses
Cardiac rehabilitation services	\$25 per visit, 36 visits, no \$ minimum	20% of eligible expenses
Accident related dental services limited to \$1500 maximum benefit per calendar year	No copayment	20% of eligible expenses
Dental anesthesia and related hospital services	No copayment	20% of eligible expenses
Infertility testing & diagnosis limited to \$1500 lifetime max benefit	Not covered	not covered
<b>Prescription Coverage</b>		
Tier 1	\$10*	
Tier 2	\$15*	
Tier 3	\$30*	
=call first for pre-authorization		
*Rates are less if ordered from Extended Supply Mail Pharmacy-This summary is an outline for general informational purposes only.		
Please refer to your Certificate of Coverage for specific coverage.		