BENEFITS	PARTICIPATING BENEFITS	NONPARTICIPATING BENEFITS
Deductible and Out-of-Pocket Maximum		
Deductible (Single/Family)	$500/$1,000	$750/$1,500
Out-of-pocket Maximum (Single/Family)	$3,000/$6,000	$4,000/$8,000
Coinsurance and Copay		
Coinsurance (e.g., inpatient, outpatient)	20% after ded	40% after ded
Office Visit (PCP/SCP)	$15/$25	40% after ded
Participating Emergency Room Visit	$100 after ded	See "Particpating Benefits"
Nonparticpating Emergency Room Visit	$200 after ded	See "Particpating Benefits"
Lifetime Maximum Plan Payment	$2,500,000	$1,000,000
Pre-existing Conditions		
Waived (entirely or partly) for qualifying pre-existing condition credit	Not covered for first 12 months	Not covered for first 12 months
Professional Services		
Immunizations	Covered 100%	Not covered
Elective Immunizations	20% after ded	Not covered
Outpatient Services		
Instacare/Urgent Care	$25	40% after ded
Kidscare	$15	Not available
Diagnostic Tests, Minor	Covered 100%	40% after ded
Diagnostic Tests, Major	20% after ded	40% after ded
Physical, Speech, and Occupational Therapy (limited to 20 visits per calendar year)	$25 copay after ded	40% after ded
Mental Health and Chemical Dependency	50% after ded	50% after ded
Not applied to the out-of-pocket maximum		
Inpatient limited to 10 days/calendar year		
Outpatient limited to 25 visits/calendar year		
Miscellaneous Services		
Maternity and Adoption	20% after ded	40% after ded
Infertility ($1,500/calendar year; $5,000/lifetime)	50% after ded	Not covered
Chiropractic (limited to 15 visits/calendar year)	Not available	50% after ded
Prescription Drugs		
Rx Deductible (Single)	$125	See "Participating Benefits"
Rx Out-of-Pocket Maximum (Single)	$4,000	See "Participating Benefits"
Up to a 30-day supply for covered medications; generic substitution required; same copay or coinsurance applies to a 90-day maintenance home delivery supply	Tier 1: $10 Tier 2: 25% Tier 3: 50%	Tier 1: $10 Tier 2: 25% Tier 3: 50%