

**Comprehensive Plan**

**The policy will pay 100% of covered expenses up to the Lifetime Maximum Benefit after you have met your Out-Of-Pocket Expenses<sup>(1)</sup>**

Lifetime Maximum Benefit	\$5,000,000										
Calendar Year Deductibles	\$1,000, \$1,500, \$2,500, \$3,500, \$5,000 Maximum <u>two</u> individual calendar year deductibles per family										
Coinsurance/Stop Loss (after the covered person has satisfied the calendar year deductible and any applicable service deductibles and co-pays) PPO and Non-PPO stop loss accumulate separately	<table border="1"> <thead> <tr> <th><u>PPO - Stop Loss</u></th> <th><u>Non-PPO - Stop Loss</u></th> </tr> </thead> <tbody> <tr> <td>100/0%-\$0</td> <td>75/25%-\$15,000</td> </tr> <tr> <td>80/20%-\$5,000</td> <td>60/40%-\$10,000</td> </tr> <tr> <td>80/20%-\$10,000</td> <td>60/40%-\$20,000</td> </tr> <tr> <td>*50/50%-\$10,000</td> <td>*50/50%-\$20,000</td> </tr> </tbody> </table> <p><i>*CO only</i></p>	<u>PPO - Stop Loss</u>	<u>Non-PPO - Stop Loss</u>	100/0%-\$0	75/25%-\$15,000	80/20%-\$5,000	60/40%-\$10,000	80/20%-\$10,000	60/40%-\$20,000	*50/50%-\$10,000	*50/50%-\$20,000
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Physician Office Visits - Co-pay <sup>(2)</sup> applies to physician office visit <u>charge</u>	<p><b>\$35 PPO<sup>(3)</sup></b></p> <p>Includes covered lab exams, x-rays and diagnostic tests up to a maximum benefit of \$150</p> <p>Non-PPO<sup>(3)</sup> - Subject to \$35 co-pay plus deductible and Non-PPO coinsurance</p>										
<p><b>Service Deductibles<sup>(2)(4)</sup></b></p> <p>*Hospital Emergency Room (per occurrence)</p> <p>*Inpatient Hospital Admission (per admission)</p> <p>*Outpatient Ambulatory Surgical Facility (per visit)</p> <p>*Outpatient MRI, CAT Scan, PET Scan and Nuclear Imaging Test (per test)</p>	<p>\$100</p> <p>Waived if admitted as an inpatient immediately following emergency room visit</p> <p>\$100</p> <p>\$100</p> <p>\$100</p>										
Outpatient Prescription Drugs Rx Co-pay Drug Card	<p>Rx Drug Co-pays:</p> <p><b>\$15 Generic, \$30 Formulary, \$40 Brand Name</b></p> <p>Co-pay applies after a separate selected \$150 or \$250 Rx calendar year deductible per covered person</p>										
Optional Benefits	<p>Supplemental Accident</p> <p>24-Hour Occupational Coverage</p> <p>Mental Illness and Nervous Disorders (<i>GA only</i>)</p>										

(1) Out-of-pocket expenses include any applicable deductibles, co-pays, coinsurance, amounts in excess of usual, reasonable and customary charges and non-covered expenses.

(2) Co-pay and service deductibles, if applicable, are in addition to the chosen calendar year deductible/coinsurance and do not apply to the calendar year deductible.

(3) After your PPO co-pay, balance of PPO office visit charge paid at 100%. Additionally, after your co-pay, x-rays, lab exams and diagnostic tests up to a maximum benefit of \$150 performed during the PPO Physician Office Visit paid at 100%. Covered expenses in excess of the \$150, and all other covered services performed during the office visit are subject to calendar year deductible and coinsurance. Non-PPO - After \$35 co-pay all covered services, including lab and testing, are subject to the calendar year deductible and Non-PPO coinsurance.

(4) Service Deductibles' Family Maximum of \$1,000 per calendar year. Once the calendar year Family Maximum is met, no further service deductibles will apply for the balance of that calendar year.