

**Benefit Highlights:**

**Copay Select<sup>SM</sup>**

**Copay Saver<sup>SM</sup>**

**Design Basics**

Calendar-Year Deductible Choices <small>(maximum 2 per family, per calendar year)</small>	You pay: \$500, \$1,000, \$1,500, \$2,500, or \$5,000	You pay: \$2,500 or \$5,000
Coinsurance After Deductible <small>(per covered person, per calendar year)</small>	You pay: 20% to \$2,000 We pay: 80% to \$8,000 then 100%	You pay: 20% to \$3,000 We pay: 80% to \$12,000 then 100%
Lifetime Maximum Benefit <small>(per covered person)</small>	\$3 million ( <small>\$5 million available</small> )	\$3 million ( <small>\$5 million available</small> )
Initial Rate Guarantee <small>(subject to benefit and address changes)</small>	12 months	12 months

**We pay the percentages below AFTER you pay the deductible unless otherwise indicated.**

**Preventive Care Benefits**

Doctor Office Visit <small>(\$300 annual max.)</small>	(not subject to deductible) History and exam: \$35 Copay X-ray and Lab: 80%	Not Covered
Child Immunizations <small>(\$300 annual max., age 0-18)</small>	Vaccine: 80% (not subject to deductible)	Not Covered
Preventive Mammogram, Pap Smear, PSA Testing	Testing: 80% (not subject to deductible)	Testing: 80%

**Outpatient Expense Benefits**

Doctor Office Visit — Illness & Injury <small>(not subject to the deductible)</small>	For history and exam: \$35 Copay	For history and exam: \$35 Copay, then 100% <small>(maximum 2 visits per person, per year — with an option to buy 2 more, see page 10)</small>
Outpatient X-ray and Lab <small>(performed in the doctor's office or elsewhere)</small>	80%	80% if performed within 14 days of surgery or confinement
Outpatient Prescription Drugs <small>(Annual maximum \$3,000 per covered person for Copay Select<sup>SM</sup>. Or choose the optional Prescription Drug Benefit Buy-Up to eliminate this annual limit. See page 10.)</small>	Generic: \$15 Copay Name-Brand preferred: \$30 Copay Name-Brand nonpreferred: \$60 Copay  <small>(Name-Brand copay is after a \$100 per person, calendar year deductible. If Generic is available, Name-Brand reimbursed at Generic price)</small>	Generic: \$15 Copay Name-Brand: Not Covered  <small>(Texas, see page 18)</small>
Surgeon, Assistant Surgeon, and Facility Fees	80%	80%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	80%	80%
Cat Scans, MRIs	80%	80%
Emergency Room Fees	Illness: 80%, \$100 Copay if not admitted Injury: 80%	Illness & Injury: 80%, \$500 Copay if not admitted
Other Covered Outpatient Expenses	80%	See page 12
<b>Inpatient Expense Benefits</b>		
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%

Dental and Vision Discounts — Programs Are Not Insurance  
Discounts through FACT membership provided by Health Allies — save up to 50% on dental and vision.

- Optional Benefits — For a complete list, see page 10.
- \$5 Million Lifetime Maximum Benefit
  - First-Dollar Accident Benefit
  - Term Life Benefit
  - Maternity Benefit
  - Enhanced Preventive Care Benefits Package
  - Two Additional Doctor Office Visits (Copay Saver)
  - Prescription Drug Benefit Buy-Up (Copay Select)

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 11-16, and the state variations on pages 17-19.