

Select Coverage 100% / 50%



Types of Coverage	PPO	Non-PPO*																																																																																																												
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Mental Health, Alcohol and Drug Abuse Services For groups with 51 or more employees** For Indiana groups with 51 or more employees*** Combined lifetime maximum of \$25,000.	Inpatient and Outpatient charges including prescription drugs—benefits payable at 50% after deductible to a maximum payment of \$5,000 per calendar year				Inpatient and Outpatient charges including prescription drugs—benefits payable at 50% of UCR after deductible to a maximum payment of \$2,500 per calendar year																																																																																																									
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* If provided by a PPO facility, services received from Non-PPO anesthesiologists, radiologists, and pathologists will be eligible for the PPO deductible and coinsurance levels, subject to UCR.

** For groups with 51 or more employees, Mental Health, Alcohol and Drug Abuse Services per calendar year will be paid as follows: For PPO inpatient charges, benefits are payable at 50% after deductible up to 10 days of confinement; the benefits for PPO outpatient charges are payable at 50% after deductible up to 30 visits. For Non PPO inpatient charges, benefits are payable at 50% after deductible up to 5 days of confinement; the benefits for Non-PPO outpatient charges are payable at 50% after deductible up to 15 visits.

*** For Indiana groups with 51 or more employees, the base plan will not include Mental Health benefits, however an optional package is available which includes Mental Health benefits covered on the same basis as any other covered expense. Alcohol and Drug Abuse Services will be paid at the 51 or more employee level as indicated in the above paragraph.

All copayments are not credited to the deductible, out-of-pocket, or coinsurance. The emergency room facility charge copayment is waived if patient is admitted within 24 hours.

Optional Benefits	PPO	Non-PPO
Prescription Drug Program <i>If there is a tier 1 equivalent available for a preferred or non-preferred tier 3 drug reimbursement will be made at the tier 1 equivalent rate.</i> <i>The copayment for the Prescription Drug Program is not credited to the deductible, out-of-pocket or coinsurance.</i>	Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$20 copayment tier 2, \$35 copayment tier 3 Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$50 copayment tier 2, \$87.50 copayment tier 3 up to a 90 day supply	
Supplemental Accident Benefit (Not available with \$2,500/\$5,000 deductible option)	\$500 per calendar year combined benefit from all sources	

All payment illustrations include payment amounts as indicated for covered benefits, subject to the terms and provisions of the Certificate.
 The outlined benefits are intended to reflect the coverages provided in the Master Policy. A more detailed explanation of coverage is provided in the Certificate.

Select Coverage 100% / 70%



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Select Coverage 100% / 70% Plus



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<p>Routine Examinations - \$500 Calendar Year Maximum Includes physical examinations including immunizations, routine mammograms, pap tests, and hearing and vision examinations.</p>	100% after office visit copayment per examination	Not covered: Immunizations, mammograms, and lab costs for pap tests are covered as specified in the Certificate																																																																																														
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<p>Emergency Room Care & Facility Charges Includes all services performed in the emergency room, including emergency room physician charges and facility.</p>	100% after PPO deductible and \$100 copayment per visit (Note: Non-PPO services are also subject to UCR)																																																																																															
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* If provided at a PPO facility, services received from Non-PPO anesthesiologists, radiologists, and pathologists will be eligible for the PPO deductible and coinsurance levels, subject to UCR

** For groups with 51 or more employees, Mental Health, Alcohol and Drug Abuse Services per calendar year will be paid as follows: For PPO inpatient charges, benefits are payable at 50% after deductible up to 10 days of confinement; the benefits for PPO outpatient charges are payable at 50% after deductible up to 30 visits. For Non-PPO inpatient charges, benefits are payable at 50% after deductible up to 5 days of confinement; the benefits for Non-PPO outpatient charges are payable at 50% after deductible up to 15 visits.

All copayments are not credited to the deductible, out-of-pocket, or coinsurance. The emergency room facility charge is waived if patient is admitted within 24 hours.

Optional Benefits	PPO	Non-PPO
<p>Prescription Drug Program <i>If there is a tier 1 equivalent available for a preferred or non-preferred tier 3 drug reimbursement will be made at the tier 1 equivalent rate.</i> <i>The copayment for the Prescription Drug Program is not credited to the deductible, out-of-pocket or coinsurance.</i></p>	<p>Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$20 copayment tier 2, \$35 copayment tier 3</p> <p>Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$50 copayment tier 2, \$87.50 copayment tier 3 up to a 90 day supply</p>	
<p>Supplemental Accident Benefit (Not available with \$0/\$2,500 deductible option)</p>	\$500 per calendar year combined benefit from all sources	

All payment illustrations include payment amounts as indicated for covered benefits, subject to the terms and provisions of the Certificate. The outlined benefits are intended to reflect the coverages provided in the Master Policy. A more detailed explanation of coverage is provided in the Certificate.

Select Coverage 80% / 60%



Types of Coverage	PPO	Non-PPO*																																																																																																																		
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<p>Routine Examinations - \$500 Calendar Year Maximum Includes physical examinations including immunizations, routine mammograms, pap tests, and hearing and vision examinations. <i>For Ohio benefits, see the Ohio Select Coverage Brochure.</i></p>	100% after office visit copayment per examination (For \$2,500/\$7,500 ded., routine benefit paid at 100% w/o copay)	Not covered: Immunizations, mammograms, and lab costs for pap tests are covered as specified in the Certificate																																																																																																																		
<p>Physician/Clinic Other Services Includes durable medical equipment, home health care, hospital visits, and other physician services. Maximums may apply to some services. See certificate for details.</p>	80% after deductible	60% of UCR charges after deductible																																																																																																																		
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<p>Mental Health, Alcohol and Drug Abuse Services For groups with 51 or more employees** For Indiana groups with 51 or more employees*** Combined lifetime maximum of \$25,000.</p>	Inpatient and Outpatient charges including prescription drugs—benefits payable at 50% after deductible to a maximum payment of \$5,000 per calendar year	Inpatient and Outpatient charges including prescription drugs—benefits payable at 50% of UCR after deductible to a maximum payment of \$2,500 per calendar year																																																																																																																		
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 - ** For groups with 50-99 employees, Mental Health, Alcohol and Drug Abuse Services per calendar year will be paid as follows: For PPO inpatient charges, benefits are payable at 50% after deductible up to 10 days of confinement; the benefits for PPO outpatient charges are payable at 50% after deductible up to 30 visits. For Non PPO inpatient charges, benefits are payable at 50% after deductible up to 5 days of confinement; the benefits for Non-PPO outpatient charges are payable at 50% after deductible up to 15 visits.
 - *** For Indiana groups with 50-99 employees, the base plan will not include Mental Health benefits, however an optional package is available which includes Mental Health benefits covered on the same basis as any other covered expense. Alcohol and Drug Abuse Services will be paid at the 51 or more employee level as indicated in the above paragraph.
- All copayments are not credited to the deductible, out-of-pocket, or coinsurance. The emergency room facility charge copayment is waived if patient is admitted within 24 hours.

Optional Benefits	PPO	Non-PPO
<p>Prescription Drug Program <i>If there is a tier 1 equivalent available for a preferred or non-preferred tier 3 drug, reimbursement will be made at the tier 1 equivalent rate.</i> <i>The copayment for the Prescription Drug Program is not credited to the deductible, out-of-pocket or coinsurance.</i></p>	<p>Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$20 copayment tier 2, \$35 copayment tier 3</p> <p>Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$50 copayment tier 2, \$87.50 copayment tier 3 up to a 90 day supply</p>	
<p>Supplemental Accident Benefit (Not available with \$2,500 deductible option)</p>	\$500 per calendar year combined benefit from all sources	

All payment illustrations include payment amounts as indicated for covered benefits, subject to the terms and provisions of the Certificate. The outlined benefits are intended to reflect the coverages provided in the Master Policy. A more detailed explanation of coverage is provided in the Certificate.

Select Coverage 90% / 70%



Types of Coverage	PPO	Non-PPO*																																																																																																																		
Out-of-Pocket Expenses <table border="1"> <thead> <tr> <th rowspan="2">Annual Deductible Option PPO/Non-PPO</th> <th rowspan="2">Number of Individual Deductibles</th> <th colspan="2">Copays</th> </tr> <tr> <th>Office Visit</th> <th>Urgent Care</th> </tr> </thead> <tbody> <tr> <td>\$250</td> <td>3</td> <td>\$20</td> <td>\$40</td> </tr> <tr> <td>\$500</td> <td>3</td> <td>\$25</td> <td>\$50</td> </tr> <tr> <td>\$750</td> <td>3</td> <td>\$25</td> <td>\$50</td> </tr> <tr> <td>\$1,000</td> <td>3</td> <td>\$30</td> <td>\$60</td> </tr> <tr> <td>\$1,500</td> <td>3</td> <td>\$40</td> <td>\$80</td> </tr> <tr> <td>\$2,500</td> <td>3</td> <td>ded./coin</td> <td>ded. coin</td> </tr> </tbody> </table> <p><i>Amounts applied toward the in-network deductible do apply toward satisfaction of the out-of-network deductible and vice versa. Amounts applied toward the in-network maximum coinsurance limit are credited to the out-of-network maximum coinsurance limit and vice versa. The maximum calendar year coinsurance limit will never be more than two times the out-of-network deductible and coinsurance.</i></p>	Annual Deductible Option PPO/Non-PPO	Number of Individual Deductibles	Copays		Office Visit	Urgent Care	\$250	3	\$20	\$40	\$500	3	\$25	\$50	\$750	3	\$25	\$50	\$1,000	3	\$30	\$60	\$1,500	3	\$40	\$80	\$2,500	3	ded./coin	ded. coin	Individual Out-of-Pocket Maximum Options <i>(includes deductible and coinsurance)</i> <table border="1"> <thead> <tr> <th>5K</th> <th>10K</th> <th>15K</th> <th>20K</th> <th>30K</th> <th>40K</th> </tr> </thead> <tbody> <tr> <td>\$750</td> <td>\$1,250</td> <td>\$1,750</td> <td>\$2,250</td> <td>\$3,250</td> <td>\$4,250</td> </tr> <tr> <td>\$1,000</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> <td>\$3,500</td> <td>\$4,500</td> </tr> <tr> <td>\$1,250</td> <td>\$1,750</td> <td>\$2,250</td> <td>\$2,750</td> <td>\$3,750</td> <td>\$4,750</td> </tr> <tr> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> <td>\$3,000</td> <td>\$4,000</td> <td>\$5,000</td> </tr> <tr> <td>\$2,000</td> <td>\$2,500</td> <td>\$3,000</td> <td>\$3,500</td> <td>\$4,500</td> <td>\$5,500</td> </tr> <tr> <td>\$3,000</td> <td>\$3,500</td> <td>\$4,000</td> <td>\$4,500</td> <td>\$5,500</td> <td>\$6,500</td> </tr> </tbody> </table>	5K	10K	15K	20K	30K	40K	\$750	\$1,250	\$1,750	\$2,250	\$3,250	\$4,250	\$1,000	\$1,500	\$2,000	\$2,500	\$3,500	\$4,500	\$1,250	\$1,750	\$2,250	\$2,750	\$3,750	\$4,750	\$1,500	\$2,000	\$2,500	\$3,000	\$4,000	\$5,000	\$2,000	\$2,500	\$3,000	\$3,500	\$4,500	\$5,500	\$3,000	\$3,500	\$4,000	\$4,500	\$5,500	\$6,500	Individual Out-of-Pocket Maximum Options <i>(includes deductible and coinsurance)</i> <table border="1"> <thead> <tr> <th>5K</th> <th>10K</th> <th>15K</th> <th>20K</th> <th>30K</th> <th>40K</th> </tr> </thead> <tbody> <tr> <td>\$1,750</td> <td>\$3,250</td> <td>\$4,750</td> <td>\$6,250</td> <td>\$9,250</td> <td>\$12,250</td> </tr> <tr> <td>\$2,000</td> <td>\$3,500</td> <td>\$5,000</td> <td>\$6,500</td> <td>\$9,500</td> <td>\$12,500</td> </tr> <tr> <td>\$2,250</td> <td>\$3,750</td> <td>\$5,250</td> <td>\$6,750</td> <td>\$9,750</td> <td>\$12,750</td> </tr> <tr> <td>\$2,500</td> <td>\$4,000</td> <td>\$5,500</td> <td>\$7,000</td> <td>\$10,000</td> <td>\$13,000</td> </tr> <tr> <td>\$3,000</td> <td>\$4,500</td> <td>\$6,000</td> <td>\$7,500</td> <td>\$10,500</td> <td>\$13,500</td> </tr> <tr> <td>\$4,000</td> <td>\$5,500</td> <td>\$7,000</td> <td>\$8,500</td> <td>\$11,500</td> <td>\$14,500</td> </tr> </tbody> </table> <p style="text-align: center;"><i>Family Out-of-Pocket Maximum is two times the Individual Out-of-Pocket Maximum</i></p>	5K	10K	15K	20K	30K	40K	\$1,750	\$3,250	\$4,750	\$6,250	\$9,250	\$12,250	\$2,000	\$3,500	\$5,000	\$6,500	\$9,500	\$12,500	\$2,250	\$3,750	\$5,250	\$6,750	\$9,750	\$12,750	\$2,500	\$4,000	\$5,500	\$7,000	\$10,000	\$13,000	\$3,000	\$4,500	\$6,000	\$7,500	\$10,500	\$13,500	\$4,000	\$5,500	\$7,000	\$8,500	\$11,500	\$14,500
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Physician Visits Includes office call charges plus diagnostic X-ray and laboratory charges on the same day related to the office visit.	100% after office visit copayment	70% of usual, customary, and reasonable (UCR) charges after deductible																																																																																																																		
Urgent Care Visits Includes urgent care diagnostic X-ray and laboratory charges on the same day related to the urgent care visit.	100% after urgent care copayment	70% of UCR charges after deductible																																																																																																																		
Routine Examinations - \$500 Calendar Year Maximum Includes physical examinations including immunizations, routine mammograms, pap tests, and hearing and vision examinations. <i>For Ohio benefits, see the Ohio Select Coverage Brochure.</i>	100% after office visit copayment per examination (For \$2,500/\$7,500 ded., routine benefit paid at 100% w/o copay)	Not covered: Immunizations, mammograms, and lab costs for pap tests are covered as specified in the Certificate																																																																																																																		
Physician/Clinic Other Services Includes durable medical equipment, home health care, hospital visits, and other physician services. Maximums may apply to some services. See certificate for details.	90% after deductible	70% of UCR charges after deductible																																																																																																																		
Hospital Services Inpatient care, including semi-private room or intensive care unit, operating room, and ancillary services. Outpatient hospital care, including all medically necessary services and supplies.	90% after deductible	70% of UCR charges after deductible																																																																																																																		
Emergency Room Care & Facility Charges Includes all services performed in the emergency room, including emergency room physician charges and facility.	90% after PPO deductible and \$100 copayment per visit (Note: Non-PPO services are also subject to UCR)																																																																																																																			
Prescription Drug Program Prescription drug copayments do not apply toward out-of-pocket maximums. Up to a 90 day supply is allowed with mail order option. <i>If there is a tier 1 equivalent available for a tier 2 or non-preferred tier 3 drug reimbursement will be made at the tier 1 equivalent rate.</i>	Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$25 copayment tier 2, \$50 copayment tier 3 Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$62.50 copayment tier 2, \$125 copayment tier 3 up to a 90 day supply																																																																																																																			
Mental Health, Alcohol and Drug Abuse Services For groups with 51 or more employees** For Indiana groups with 51 or more employees*** Combined lifetime maximum of \$25,000.	Inpatient and Outpatient charges including prescription drugs—benefits payable at 50% after deductible to a maximum payment of \$5,000 per calendar year	Inpatient and Outpatient charges including prescription drugs—benefits payable at 50% of UCR after deductible to a maximum payment of \$2,500 per calendar year																																																																																																																		
Lifetime Maximum	Combined benefits from all sources not to exceed \$5,000,000																																																																																																																			

- * If provided by a PPO facility, services received from Non-PPO anesthesiologists, radiologists, and pathologists will be eligible for the PPO deductible and coinsurance levels, subject to UCR.
 - ** For groups with 51 or more employees, Mental Health, Alcohol and Drug Abuse Services per calendar year will be paid as follows: For PPO inpatient charges, benefits are payable at 50% after deductible up to 10 days of confinement; the benefits for PPO outpatient charges are payable at 50% after deductible up to 30 visits. For Non PPO inpatient charges, benefits are payable at 50% after deductible up to 5 days of confinement; the benefits for Non-PPO outpatient charges are payable at 50% after deductible up to 15 visits.
 - *** For Indiana groups with 51 or more employees, the base plan will not include Mental Health benefits, however an optional package is available which includes Mental Health benefits covered on the same basis as any other covered expense. Alcohol and Drug Abuse Services will be paid at the 51 or more employee level as indicated in the above paragraph.
- All copayments are not credited to the deductible, out-of-pocket, or coinsurance. The emergency room facility charge copayment is waived if patient is admitted within 24 hours.

Optional Benefits	PPO	Non-PPO
Prescription Drug Program <i>If there is a tier 1 equivalent available for a preferred or non-preferred tier 3 drug, reimbursement will be made at the tier 1 equivalent rate.</i> The copayment for the Prescription Drug Program is not credited to the deductible, out-of-pocket or coinsurance.	Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$20 copayment tier 2, \$35 copayment tier 3 Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$50 copayment tier 2, \$87.50 copayment tier 3 up to a 90 day supply	
Supplemental Accident Benefit <i>(Not available with \$2,500 deductible option)</i>	\$500 per calendar year combined benefit from all sources	

All payment illustrations include payment amounts as indicated for covered benefits, subject to the terms and provisions of the Certificate. The outlined benefits are intended to reflect the coverages provided in the Master Policy. A more detailed explanation of coverage is provided in the Certificate.