

Group MidMed Plan | Underwritten by ACT Trust

IN NETWORK (PPO) COVERED *	BRONZE PLAN	GOLD PLAN
Schedule of Benefits		
Policy Year Deductible (Individual/Family)	\$250/\$750	\$500/\$1,500
In-patient Care		
Surgery-Inpatient, Physician Services	70%	80%
Hospital Inpatient (Facility)	70%	80%
Other Hospital Charges (Including hospital based professional charges)	70%	80%
Physician Services (Inpatient visits)	70%	80%
Out-patient Care Categories		
Physician/Specialist Office Visit (Co-pay does not apply to any other service rendered in the office.)	\$20 Co-pay Then 100%	\$20 Co-pay Then 100%
Other Office Services provided during Office Visit	70% No Calendar Deductible	80% No Calendar Deductible
Urgent Care Facility	70%	80%
Surgery, Outpatient	70%	80%
Maternity Care (Insured Person and covered spouse only)	70%	80%
Emergency Room (if not admitted inpatient)	1st \$100 then 70%	1st \$100 then 80%
Cardiac, Occupational, Physical, Pulmonary & Speech Therapies (subject to 20 visits/calendar year max per category)	70%	80%
Transplant-Related Expenses	70%	80%
Routine Physical Exams, including Well Child Care	\$15 Co-pay Then 100% \$100 Calendar Benefit	\$15 Co-pay Then 100% \$300 Calendar Benefit
Other Services	70%	80%
Mental Health/Substance Abuse	Varies by State	Varies by State
Calendar Year Plan Maximum	\$25,000	\$50,000
Lifetime Plan Maximum	\$100,000	\$150,000
Prescription Drug Card	\$15 co-pay	\$15 co-pay

Out-Patient Generic Formulary Prescription Drugs (up to \$2400/year or \$200 month per person).

Limited to 90 day supply; subject to \$15 co-pay per 30 day supply. Brand RX is discount only.

Calendar year deductible applies to every expense listed below, unless other wise noted. Co-payments are not applied to the Calendar Year Deductible. This is only a summary of the Midmed Limited Benefit Medical insurance plan benefits and is subject to the Terms, Conditions, state mandated benefits and limitations of the group policy. This is not comprehensive major medical coverage or designed as a substitute for comprehensive major medical coverage. Out of Network is covered at 60%. *After deductible.

Bronze Rates	weekly	monthly	Gold Rates	weekly	monthly
	Member Only	\$69.03		\$299.13	Member Only
Member Plus Spouse	\$182.97	\$576.20	Member Plus Spouse	\$160.52	\$659.59
Member Plus Child	\$113.31	\$482.34	Member Plus Child	\$131.19	\$568.49
Member & Family	\$175.03	\$758.46	Member & Family	\$209.46	\$907.66

Note: Rx-Tiered Discount Benefit is included with your association membership. Premiums include insurance and noninsurance benefits. For a price breakdown, please contact your agent.