



<b>Plan 1</b>		
	<b>In-Net</b>	<b>Out-Net</b>
Deductibles (indvl/fam)	\$250/\$750	\$500/\$1,000
Cal Year Copay Max - Individual	\$2K/\$3K (exclds ded)	\$4K/\$6K (exclds ded)
- Family	\$4K/\$6K (exclds ded)	\$8K/\$12K (exclds ded)
Lifetime Max	None	None
Physician & Specialist Office Visits	\$20/No Deduct	30%/40% of sched
Acupuncture (12 visits*)	10% or 20%	30%/40% of sched
Lab, X-Ray, and Diagnostic testing	10% or 20%	30%/40% of sched
Advanced Imaging (CT, CAT, MRI)*	10% or 20%	30%/40% of sched
Allergy testing	10% or 20%	30%/40% of sched
Annual routine phys exam, eye/ear	No Copay/No Ded	30%/40% of sched
Outpatient Surgery*	\$100/10% or 20%	30%/40% of sched
Inpatient Hospital*	\$100/10% or 20%	30%/40% of sched
Emgcy Rm Srvc (unless admitted)	\$100/10% or 20%	30%/40% of sched
Ambulance	10% or 20%	30%/40% of sched
Prosthetics/Orthotics*	10% or 20%	30%/40% of sched
Durable Medical Equipment*	10% or 20%	30%/40% of sched
Mental Health & Substance Abuse - Inpatient*	\$100/10% or 20%	30%/40% of sched
Mental Health & Substance Abuse - Outpatient	\$20/No Deduct	30%/40% of sched
Home Healthcare*	10% or 20%	30%/40% of sched
Hospice*	No Copay/No Ded	30%/40% of sched
Pregnancy - prenatal & postnatal	\$20/No Deduct	30%/40% of sched
Diagnosis/treatment of infertility	Not Covered	Not Covered
Tubal Ligation/Elective Abortion	10% or 20%	30%/40% of sched
Vasectomy	10% or 20%	30%/40% of sched
Diabetes self-management training	\$20/No Deduct	30%/40% of sched
Chiropractic (12 visit*)	10% or 20%	30%/40% of sched
Skilled Nursing Facility*	10% or 20%	30%/40% of sched
Physical Therapy (12 visits*)	10% or 20%	30%/40% of sched
Speech Therapy (12 visits*)	10% or 20%	30%/40% of sched
Occupational Therapy (12 visits*)	10% or 20%	30%/40% of sched
Pharmacy Retail**	\$10/\$25/\$50/\$100	NA
Pharmacy OTC***	\$0	NA
Phrmcy Mail Order - 90 day suply**	2X=90 Days	NA

\*Prior Authorization Required. For specific questions regarding pre authorization requirements please refer to the plan document.

\*\* Pharmacy does not apply to the medical deductible or out of pocket max.

\*\*\*Over the counter medications are covered at no cost but require prescription from your physician.

NOTE: The benefits listed above do not list benefit limitations or exclusions of the contracts. For specific questions regarding benefits please refer to the plan document as the above is just a summary



**Plan 2**

	<b>In-Net</b>	<b>In-Net</b>
Deductibles (indvl/fam)	\$500/\$1,000	\$500/\$1,000
Cal Year Copay Max - Individual	\$3K (exclds ded)	\$3K (exclds ded)
- Family	\$6K (exclds ded)	\$6K (exclds ded)
Lifetime Max	None	None
Physician & Specialist Office Visits	\$20/No Deduct	\$20/No Deduct
Acupuncture (12 visits*)	20% or 30%	20% or 30%
Lab, X-Ray, and Diagnostic testing	20% or 30%	20% or 30%
Advanced Imaging (CT, CAT, MRI)*	20% or 30%	20% or 30%
Allergy testing	20% or 30%	20% or 30%
Annual routine phys exam, eye/ear	No Copay/No Ded	No Copay/No Ded
Outpatient Surgery*	\$150/20% or 30%	\$150/20% or 30%
Inpatient Hospital*	\$150/20% or 30%	\$150/20% or 30%
Emgcy Rm Srvc (unless admitted)	\$150/20% or 30%	\$150/20% or 30%
Ambulance	20% or 30%	20% or 30%
Prosthetics/Orthotics*	20% or 30%	20% or 30%
Durable Medical Equipment*	20% or 30%	20% or 30%
Mental Health & Substance Abuse - Inpatient*	\$150/20% or 30%	\$150/20% or 30%
Mental Health & Substance Abuse - Outpatient	\$20/No Deduct	\$20/No Deduct
Home Healthcare*	20% or 30%	20% or 30%
Hospice*	No Copay/No Ded	No Copay/No Ded
Pregnancy - prenatal & postnatal	\$20/No Deduct	\$20/No Deduct
Diagnosis/treatment of infertility	Not Covered	Not Covered
Tubal Ligation/Elective Abortion	20% or 30%	20% or 30%
Vasectomy	20% or 30%	20% or 30%
Diabetes self-management training	\$20/No Deduct	\$20/No Deduct
Chiropractic (12 visit*)	20% or 30%	20% or 30%
Skilled Nursing Facility*	20% or 30%	20% or 30%
Physical Therapy (12 visits*)	20% or 30%	20% or 30%
Speech Therapy (12 visits*)	20% or 30%	20% or 30%
Occupational Therapy (12 visits*)	20% or 30%	20% or 30%
Pharmacy Retail**	\$15/\$30/\$60/\$120	\$15/\$30/\$60/\$120
Pharmacy OTC***	\$0	\$0
Phrmcy Mail Order - 90 day suply**	2X=90 Days	2X=90 Days

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<b>Plan 3</b>		
	<b>In-Net</b>	<b>Out-Net</b>
Deductibles (indvl/fam)	\$1,000/\$2,000	\$1,500/\$3,000
Cal Year Copay Max - Individual	\$4K (exclds ded)	\$7K (exclds ded)
- Family	\$8K (exclds ded)	\$14K (exclds ded)
Lifetime Max	None	None
Physician & Specialist Office Visits	\$20/No Deduct	40%/50% of sched
Acupuncture (12 visits*)	20% or 30%	40%/50% of sched
Lab, X-Ray, and Diagnostic testing	20% or 30%	40%/50% of sched
Advanced Imaging (CT, CAT, MRI)*	20% or 30%	40%/50% of sched
Allergy testing	20% or 30%	40%/50% of sched
Annual routine phys exam, eye/ear	No Copay/No Ded	40%/50% of sched
Outpatient Surgery*	\$200/20% or 30%	40%/50% of sched
Inpatient Hospital*	\$200/20% or 30%	40%/50% of sched
Emgcy Rm Srvc (unless admitted)	\$200/20% or 30%	40%/50% of sched
Ambulance	20% or 30%	40%/50% of sched
Prosthetics/Orthotics*	20% or 30%	40%/50% of sched
Durable Medical Equipment*	20% or 30%	40%/50% of sched
Mental Health & Substance Abuse - Inpatient*	\$200/20% or 30%	40%/50% of sched
Mental Health & Substance Abuse - Outpatient	\$20/No Deduct	40%/50% of sched
Home Healthcare*	20% or 30%	40%/50% of sched
Hospice*	No Copay/No Ded	40%/50% of sched
Pregnancy - prenatal & postnatal	\$20/No Deduct	40%/50% of sched
Diagnosis/treatment of infertility	Not Covered	Not Covered
Tubal Ligation/Elective Abortion	20% or 30%	40%/50% of sched
Vasectomy	20% or 30%	40%/50% of sched
Diabetes self-management training	\$20/No Deduct	40%/50% of sched
Chiropractic (12 visit*)	20% or 30%	40%/50% of sched
Skilled Nursing Facility*	20% or 30%	40%/50% of sched
Physical Therapy (12 visits*)	20% or 30%	40%/50% of sched
Speech Therapy (12 visits*)	20% or 30%	40%/50% of sched
Occupational Therapy (12 visits*)	20% or 30%	40%/50% of sched
Pharmacy Retail**	\$20/\$40/\$75/\$150	NA
Pharmacy OTC***	\$0	NA
Phrmcy Mail Order - 90 day suply**	2X=90 Days	NA

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<b>Plan 4 (HSA)</b>		
	<b>In-Net</b>	<b>Out-Net</b>
Deductibles (indvl/fam)	\$2,000/\$4,000	\$2,000/\$4,000
Cal Year Copay Max - Individual		\$4K
- Family		\$8K
Lifetime Max	None	None
Physician & Specialist Office Visits	\$20/No Deduct	30%/40% of sched
Acupuncture (12 visits*)	10% or 20%	30%/40% of sched
Lab, X-Ray, and Diagnostic testing	10% or 20%	30%/40% of sched
Advanced Imaging (CT, CAT, MRI)*	10% or 20%	30%/40% of sched
Allergy testing	10% or 20%	30%/40% of sched
Annual routine phys exam, eye/ear	No Copay/No Ded	30%/40% of sched
Outpatient Surgery*	\$100/10% or 20%	\$100 / 30% or 40%
Inpatient Hospital*	\$100/10% or 20%	\$100 / 30% or 40%
Emgcy Rm Srvc (unless admitted)	\$100/10% or 20%	\$100 / 30% or 40%
Ambulance	10% or 20%	30%/40% of sched
Prosthetics/Orthotics*	10% or 20%	30%/40% of sched
Durable Medical Equipment*	10% or 20%	30%/40% of sched
Mental Health & Substance Abuse - Inpatient*	\$100/10% or 20%	\$100 / 30% or 40%
Mental Health & Substance Abuse - Outpatient	\$20/No Deduct	30%/40% of sched
Home Healthcare*	10% or 20%	30%/40% of sched
Hospice*	No Copay/No Ded	30%/40% of sched
Pregnancy - prenatal & postnatal	\$20/No Deduct	30%/40% of sched
Diagnosis/treatment of infertility	Not Covered	Not Covered
Tubal Ligation/Elective Abortion	10% or 20%	30%/40% of sched
Vasectomy	10% or 20%	30%/40% of sched
Diabetes self-management training	\$20/No Deduct	30%/40% of sched
Chiropractic (12 visit*)	10% or 20%	30%/40% of sched
Skilled Nursing Facility*	10% or 20%	30%/40% of sched
Physical Therapy (12 visits*)	10% or 20%	30%/40% of sched
Speech Therapy (12 visits*)	10% or 20%	30%/40% of sched
Occupational Therapy (12 visits*)	10% or 20%	30%/40% of sched
Pharmacy Retail**	\$10/\$25/\$50/\$100	NA
Pharmacy OTC***		NA
Phrmcy Mail Order - 90 day suply**	2X=90 Days	NA

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<b>Plan 5 (HSA)</b>		
	<b>In-Net</b>	<b>Out-Net</b>
Deductibles (indvl/fam)	\$3,000/\$6,000	\$3,000/\$6,000
Cal Year Copay Max - Individual		\$4.5K
- Family		\$9K
Lifetime Max	None	None
Physician & Specialist Office Visits	\$20/No Deduct	30%/40% of sched
Acupuncture (12 visits*)	20% or 30%	30%/40% of sched
Lab, X-Ray, and Diagnostic testing	20% or 30%	30%/40% of sched
Advanced Imaging (CT, CAT, MRI)*	20% or 30%	30%/40% of sched
Allergy testing	20% or 30%	30%/40% of sched
Annual routine phys exam, eye/ear	No Copay/No Ded	30%/40% of sched
Outpatient Surgery*	\$200/20% or 30%	\$200 / 30% or 40%
Inpatient Hospital*	\$200/20% or 30%	\$200 / 30% or 40%
Emgcy Rm Srvc (unless admitted)	\$200/20% or 30%	\$200 / 30% or 40%
Ambulance	20% or 30%	30%/40% of sched
Prosthetics/Orthotics*	20% or 30%	30%/40% of sched
Durable Medical Equipment*	20% or 30%	30%/40% of sched
Mental Health & Substance Abuse - Inpatient*	\$200/20% or 30%	\$200 / 30% or 40%
Mental Health & Substance Abuse - Outpatient	\$20/No Deduct	30%/40% of sched
Home Healthcare*	20% or 30%	30%/40% of sched
Hospice*	No Copay/No Ded	30%/40% of sched
Pregnancy - prenatal & postnatal	\$20/No Deduct	30%/40% of sched
Diagnosis/treatment of infertility	Not Covered	Not Covered
Tubal Ligation/Elective Abortion	20% or 30%	30%/40% of sched
Vasectomy	20% or 30%	30%/40% of sched
Diabetes self-management training	\$20/No Deduct	30%/40% of sched
Chiropractic (12 visit*)	20% or 30%	30%/40% of sched
Skilled Nursing Facility*	20% or 30%	30%/40% of sched
Physical Therapy (12 visits*)	20% or 30%	30%/40% of sched
Speech Therapy (12 visits*)	20% or 30%	30%/40% of sched
Occupational Therapy (12 visits*)	20% or 30%	30%/40% of sched
Pharmacy Retail**	\$20/\$40/\$75/\$150	NA
Pharmacy OTC***	\$0	NA
Phrmcy Mail Order - 90 day suply**	2X=90 Days	NA

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