

PLAN FEATURES

ESSENTIAL BENEFITS MAXIMUM: \$2,000,000 PER YEAR
LIFETIME MAXIMUM: UNLIMITED

PREFERRED BENEFITS - COXHEALTH SPECIALTY SERVICES

WELLNESS PROGRAM - Employee Level I	\$0 - No Cost
ACCIDENT BENEFIT - \$1000 maximum per person per calendar year	\$0 - No Cost
HEALTH BENEFIT - Preventive Health Services mandated by PHSA Section 2713	\$0 - No Cost
PRESCRIPTION DRUG BENEFIT - \$0 copay generics: simvastatin & citalopram	\$0 - No Cost
DENTAL BENEFIT - Preventive Coverage	\$0 - No Cost
VISION BENEFIT - Preventive Coverage	\$0 - No Cost
EMPLOYEE ASSISTANCE PROGRAM	\$0 - No Cost
SMOKING CESSATION BENEFIT - Coverage for: Chantix & bupropion under Prescription Drug Benefits	

	<i>IN-NETWORK PROVIDERS</i>	<i>OUT-OF-NETWORK PROVIDERS</i>
DEDUCTIBLE Options Family = 3 x Individual	\$1000, \$1500, \$2000, \$2500, \$3500, \$5000, \$7500, or \$10,000	2 x
OUT OF POCKET MAXIMUM Options plus deductible Family = 2x Individual	\$2500, \$3000, \$4000, \$5000, or \$10,000*	2.5x*

STANDARD BENEFITS - IN-NETWORK PROVIDERS & SERVICES

INPATIENT HOSPITALIZATION	0 %, 10%, 20%, or 30%
OUTPATIENT HOSPITAL SERVICES	0 %, 10%, 20%, or 30%
PHYSICIAN OFFICE VISIT - includes all services billed through office	\$30 unlimited visits (eVisits - \$10)
URGENT CARE SERVICES	\$75 copay
EMERGENCY ROOM SERVICES	0 %, 10%, 20%, or 30%
AMBULANCE	0 %, 10%, 20%, or 30%
IMMUNIZATIONS - as mandated by PHSA Section 2713	\$0 per immunization
DIAGNOSTIC X-RAY, LAB, ECHO, EKG, EEG, PATHOLOGY	0 %, 10%, 20%, or 30%
HOME HEALTH, HOSPICE, SKILLED NURSING SERVICES	0 %, 10%, 20%, or 30%
DURABLE MEDICAL EQUIPMENT	0 %, 10%, 20%, or 30%
DISPOSABLE MEDICAL SUPPLIES	0 %, 10%, 20%, or 30%
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	Copay same as for Physician Services
CHIROPRACTIC SERVICES	Copay same as for Physician Services

NON-PREFERRED BENEFITS - OUT-OF-NETWORK PROVIDERS

OUT OF NETWORK BENEFITS	30%(0%), 40%(10%), 50%(20% or 30%) ²
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PRESCRIPTION DRUG BENEFITS

	<u>Retail</u>	<u>Mail</u>
TIER 1 - MOST GENERICS¹ 30 day supply	\$10 copay	\$ 5 copay
PHARMACY DEDUCTIBLE Options - Applies to Tiers 2, 3, & 4 only	\$0, \$100, \$250, \$500, \$1000, or \$2000	
TIER 2 - PREFERRED BRAND NAME 30 day supply	\$35 copay	\$25 copay
TIER 3 - NON-PREFERRED BRAND NAME 30 day supply	\$75 copay	\$50 copay
TIER 4 - SPECIALTY 30 day supply	\$100 copay	N/A

¹ Generics could fall into any tier. Please consult the formulary. Mail order available on maintenance medications only for 90 days supply.

² All Out-of-Network charges are subject to Usual and Customary charge reductions.

* 100% plans have \$0 out-of-pocket maximum for In-Network services; out-of-pocket maximum for Out-of-Network services is \$6,250.

This is only a brief summary of benefits, which is not intended to be comprehensive. Your Evidence of Coverage is the governing document for benefit information.