

Individual Medical Plan Offerings (The deductibles, co-payments and co-insurance percentages below represent what you pay.)

INDIVIDUAL PLANS	MAXIMIZER		BENEFICIAL Rx (PPO)		BENEFICIAL VALUE (PPO)		HSA CHOICE		HSA VALUE	
Plan year deductible options, individual (family deductible is 3x the individual; HSA is 2x)	\$1,000 / \$2,500 / \$5,000		\$1,000 / \$2,500 / \$5,000		\$1,000 / \$2,500 / \$5,000 / \$7,500		\$1,500 (individual) \$3,000 (family)*		\$2,800 (individual) \$5,600 (family)*	
Out-of-pocket maximum, per person (after deductible)	\$5,000	\$10,000	\$3,000	\$6,000	\$5,000	\$10,000	\$3,500 (individual) \$7,000 (family)	no maximum	\$2,200 (individual) \$4,400 (family)	no maximum
PREVENTIVE CARE	Member Responsibility		Member Responsibility		Member Responsibility		Member Responsibility		Member Responsibility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual women's exam — pap, pelvic, breast	\$20 co-pay*	50%	\$15 co-pay*	40%	\$25 co-pay*	50%	20%*	40%	50%*	50%
Women's routine mammogram	\$20 co-pay*	50%	\$15 co-pay*	40%	\$25 co-pay*	50%	20%*	40%	50%*	50%
Well-baby care	\$20 co-pay*	Not covered	\$15 co-pay*	Not covered	\$25 co-pay*	Not covered	20%*	40%	50%*	50%
Routine physical exams	\$20 co-pay*	Not covered	\$15 co-pay*	Not covered	\$25 co-pay*	Not covered	20%*	40%	50%*	50%
Immunizations	\$0*	Not covered	\$0*	Not covered	\$0*	Not covered	20%*	40%	50%*	50%
PROFESSIONAL SERVICES										
Office visits	\$20 co-pay*	50%	First 3 at \$15**	40%	First 3 at \$25**	50%	20%	40%	50%	50%
Alternative care (\$1,000 per plan year limit) Chiropractic, naturopathic and acupuncture	\$20 co-pay*	50%	First 3 at \$15**	40%	First 3 at \$25**	50%	20%	40%	50%	50%
MATERNITY										
All pre/post office visits and doctor delivery; hospital charges	30%	50%	20%	40%	30%	50%	20%	40%	50%	50%
HOSPITAL SERVICES										
Inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	30%	50%	20%	40%	30%	50%	20%	40%	50%	50%
EMERGENCY SERVICES										
Urgent care	\$20 co-pay*	50%	First 3 at \$15**	40%	\$25 co-pay**	50%	20%	40%	50%	50%
Emergency room (deductible applies)	30% after \$100 co-pay		20% after \$100 co-pay		30% after \$100 co-pay		20%		50%	
Ambulance	30%		20%		30%		20%		50%	
OTHER FACILITIES AND SERVICES										
Lab and X-ray services; rehabilitation services; medical supplies and devices; in-hospital care; home healthcare	30%	50%	20%	40%	30%	50%	20%	40%	50%	50%
Prescription services	\$15 generics or 50% brand*; \$5,000 annual maximum benefit		\$15 generics or 50% brand*; \$5,000 annual maximum benefit		optional***		30%		50%	
Lifetime maximum	\$2,000,000 (\$250,000 out-of-network)		\$2,000,000 (\$250,000 out-of-network)		\$2,000,000 (\$250,000 out-of-network)		\$2,000,000 (\$250,000 out-of-network)		\$2,000,000 (\$250,000 out-of-network)	
Accident benefit	Deductible waived for treatment completed within 90 days of accident.		Deductible waived for treatment completed within 90 days of accident.		Deductible waived for treatment completed within 90 days of accident; \$10,000 per person, per year maximum		Paid as any other illness subject to deductible/co-insurance.		Paid as any other illness subject to deductible/co-insurance.	

* Deductible waived. * Family deductible applies when an individual and a spouse or one (1) or more dependents are enrolled. Therefore, prior to benefits being paid, the entire family deductible must be met.

** Beneficial plans pay first three office visits with a co-payment, which may be used for either office visits or urgent care for illness and injury. Alternative care includes an additional three visits with a co-payment. Thereafter, the deductible and co-insurance apply for additional office visits and alternative care.

*** Can purchase prescription rider separately; benefit is \$15 generic or 50% brand, \$2,000 maximum benefit; deductible waived.