



The **One** making health insurance more affordable.



70%/60% Individual POS Plans	\$20 / \$500		\$20 / \$1,000		\$20 / \$2,000		\$20 / \$3,000		\$20 / \$5,000		\$20 / \$10,000	
	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	In-Network	Out-of-Network
Lifetime Max	\$6,000,000		\$6,000,000		\$6,000,000		\$6,000,000		\$6,000,000		\$6,000,000	
Deductible (per benefit year) - 3 Maximum per family	500	1000	1000	2000	2000	4000	3000	6000	5000	10,000	10,000	20,000
Out of Pocket Max (per benefit year) - 3 Maximum per family	2500	None	2500	None	2500	None	2500	None	2500	None	2500	None
Medical Benefits shown with Co-pays not subject to deductibles												
PCP Visits • Office Visits • X-ray and Lab when performed in office • Immunizations	\$20	40%	\$20	40%	\$20	40%	\$20	40%	\$20	40%	\$20	40%
Specialist Visits • X-ray and Lab when performed in office • Allergy Testing and Treatment	\$55	40%	\$55	40%	\$55	40%	\$55	40%	\$55	40%	\$55	40%
Preventive Screenings for Adults and Children - PCP & Specialist	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered
Mammograms	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Emergency Services • Copay waived if admitted to hospital	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
Urgent Care	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55
Ambulance • When Medically Necessary	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
Inpatient Hospital	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%
Outpatient Hospital / Facility, Including: • X-Ray, Lab, Diagnostic Services • MRI, CAT & PET Scans, Other Nuclear Med • Surgery, Anesthesia, Etc. • Chemotherapy, Radiation Treatment	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%
Short Term Therapies • No Visit Limits • Physical, Speech, Occupational and Respiratory Therapies • Cardiac and Pulmonary Rehabilitation	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%
Chiropractic Services • Limited to 24 Visits	\$10 Copay	Not Covered	\$10 Copay	Not Covered	\$10 Copay	Not Covered	\$10 Copay	Not Covered	\$10 Copay	Not Covered	\$10 Copay	Not Covered
DME, Prosthetics, Orthoses • Limited to \$2,500 Annual Max, All Combined	30%	Not Covered	30%	Not Covered	30%	Not Covered	30%	Not Covered	30%	Not Covered	30%	Not Covered
Transplants	30%	Not Covered	30%	Not Covered	30%	Not Covered	30%	Not Covered	30%	Not Covered	30%	Not Covered
Home Health Care • Limited to 30 Days, IN and OON Combined	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%
Skilled Nursing Facility • Limited to 30 Days, IN and OON Combined	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%
Hospice	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%	30%	40%
RX • Tier 1 - Preferred Generic - No Deductible • Tier 2 - Preferred Formulary Brand • Tier 3 - Non Preferred Brand and a few Non Preferred Generic • Tier 4 - Self-Administered Injectable Drugs • RX Deductible applies to Tier 2, Tier 3, & Tier 4 and must be satisfied before copays apply • Retail must be obtained from Participating Pharmacies only (except for Emergency) • Mail Order must be obtained from Caremark and Participating Pharmacies that offer Mail Order • To determine the specific cost of your medication, please refer to the Preferred Drug List	\$100 Deductible - Does Not Apply To Tier 1 RETAIL: \$10 Copay MAIL ORDER: \$35 Copay \$50 Copay \$100 Copay	Does Not Apply To Tier 1 MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered	\$250 Deductible - Does Not Apply To Tier 1 RETAIL: \$10 Copay MAIL ORDER: \$35 Copay \$50 Copay \$100 Copay	Does Not Apply To Tier 1 MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered	\$250 Deductible - Does Not Apply To Tier 1 RETAIL: \$10 Copay MAIL ORDER: \$35 Copay \$50 Copay \$100 Copay	Does Not Apply To Tier 1 MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered	\$250 Deductible - Does Not Apply To Tier 1 RETAIL: \$10 Copay MAIL ORDER: \$35 Copay \$50 Copay \$100 Copay	Does Not Apply To Tier 1 MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered	\$500 Deductible - Does Not Apply To Tier 1 RETAIL: \$10 Copay MAIL ORDER: \$35 Copay \$50 Copay \$100 Copay	Does Not Apply To Tier 1 MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered	\$500 Deductible - Does Not Apply To Tier 1 RETAIL: \$10 Copay MAIL ORDER: \$35 Copay \$50 Copay \$100 Copay	Does Not Apply To Tier 1 MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered
Dental • Preventative Cleanings for Adults and Children, 1 each six month period • Diagnostic Services • Emergency care • Restorative services • Crowns and jackets • Orthodontic care • All care must be received from DeltaCare provider	\$20 Copay Various Copays	Not Covered Not Covered	\$20 Copay Various Copays	Not Covered Not Covered	\$20 Copay Various Copays	Not Covered Not Covered	\$20 Copay Various Copays	Not Covered Not Covered	\$20 Copay Various Copays	Not Covered Not Covered	\$20 Copay Various Copays	Not Covered Not Covered
Vision • One Exam every 12 months • Exam must be received from Avesis provider	\$15 Copay	Not Covered	\$15 Copay	Not Covered	\$15 Copay	Not Covered	\$15 Copay	Not Covered	\$15 Copay	Not Covered	\$15 Copay	Not Covered

All medical benefits subject to benefit year deductible unless specifically noted with a copay.

All plans are subject to a twelve (12) month waiting period for pre-existing conditions except when a condition is disclosed on the application at the time of medical underwriting and the policy is approved. A pre-existing condition is a condition for which medical advice, diagnosis, care, treatment, or prescribed drug was recommended or received within the 12-month period prior to your effective date of coverage.

This summary is a partial description of coverage and does not detail all benefits, limitations and exclusions. Please consult the Member Contract and Schedule of Benefits to determine the exact terms, conditions and scope of coverage.



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100%/60% QHD Individual POS Plans	\$1,250 / \$2,500		\$3,000 / \$5,500		\$5,000 / \$10,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Max	\$6,000,000		\$6,000,000		\$6,000,000	
Deductible (per benefit year)	1250	2500	3000	6000	5000	10,000
Out of Pocket Max (per benefit year)	1250	2500	3000	6000	5000	10,000
Medical Benefits shown with Co-pays not subject to deductibles						
PCP and Specialist Visits <ul style="list-style-type: none"> Office Visits X-ray and Lab when performed in office Immunizations Allergy Testing and Treatment 	Ded	40%	Ded	40%	Ded	40%
Preventive Screenings for Adults and Children - PCP & Specialist	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered
Mammograms	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Emergency Services <ul style="list-style-type: none"> Copay waived if admitted to hospital 	Ded	Ded	Ded	Ded	Ded	Ded
Urgent Care	Ded	Ded	Ded	Ded	Ded	Ded
Ambulance <ul style="list-style-type: none"> When Medically Necessary 	Ded	Ded	Ded	Ded	Ded	Ded
Inpatient Hospital	Ded	40%	Ded	40%	Ded	40%
Outpatient Hosp/Facility <ul style="list-style-type: none"> X-Ray, Lab, Diagnostic Services MRI, CAT & PET Scans, Other Nuclear Med Surgery, Anesthesia, Etc. Chemotherapy, Radiation Treatment 	Ded	40%	Ded	40%	Ded	40%
Short Term Therapies <ul style="list-style-type: none"> No Visit Limits Physical, Speech, Occupational and Respiratory Therapies Cardiac and Pulmonary Rehabilitation 	Ded	40%	Ded	40%	Ded	40%
Chiropractic Services	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
DME, Prosthetics, Orthoses <ul style="list-style-type: none"> Limited to \$2,500 Annual Max, All Combined 	Ded	Not Covered	Ded	Not Covered	Ded	Not Covered
Transplants	Ded	Not Covered	Ded	Not Covered	Ded	Not Covered
Home Health Care <ul style="list-style-type: none"> Limited to 30 Days, IN and OON Combined 	Ded	40%	Ded	40%	Ded	40%
Skilled Nursing Facility <ul style="list-style-type: none"> Limited to 30 Days, IN and OON Combined 	Ded	40%	Ded	40%	Ded	40%
Hospice	Ded	40%	Ded	40%	Ded	40%
RX <ul style="list-style-type: none"> Tier 1 - Preferred Generic Tier 2 - Preferred Formulary Brand Tier 3 - Non Preferred Brand and a few Non Preferred Generic Tier 4 - Self-Administered Injectable Drugs Subject to Plan Deductible Once Out of Pocket is met, RX copayment is no longer required Retail must be obtained from Participating Pharmacies only (except for Emergency) Mail Order must be obtained from Caremark and Participating Pharmacies that offer Mail Order 	RETAIL: \$10 Copay \$35 Copay \$50 Copay \$100 Copay	MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered	RETAIL: \$10 Copay \$35 Copay \$50 Copay \$100 Copay	MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered	RETAIL: \$10 Copay \$35 Copay \$50 Copay \$100 Copay	MAIL ORDER: \$10 Copay \$70 Copay \$150 Copay Not Covered
Dental <ul style="list-style-type: none"> Preventative Cleanings for Adults and Children, 1 each six month period Diagnostic Services Emergency care Restorative services; Crowns and jackets Orthodontic care Plan Deductible does not apply All care must be received from DeltaCare provider 	\$20 Copay Various Copays	Not Covered Not Covered	\$20 Copay Various Copays	Not Covered Not Covered	\$20 Copay Various Copays	Not Covered Not Covered
Vision <ul style="list-style-type: none"> Plan Deductible does not apply One Exam every 12 months Exam must be received from Avesis provider 	\$15 Copay	Not Covered	\$15 Copay	Not Covered	\$15 Copay	Not Covered

All medical benefits subject to benefit year deductible unless specifically noted with a copay.

All plans are subject to a twelve (12) month waiting period for pre-existing conditions except when a condition is disclosed on the application at the time of medical underwriting and the policy is approved. A pre-existing condition is a condition for which medical advice, diagnosis, care, treatment, or prescribed drug was recommended or received within the 12-month period prior to your effective date of coverage.

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