PLAN A	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
ESSENTIAL BENEFITS – MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED	
Note: *The maximums listed are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total that may be split between Network and Non-Network Providers.*		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Each Covered Person	$750.00	$1,500.00
Per Family Unit	Not Applicable	Not Applicable
CO-PAYMENTS		
• **Physician Visits**	$35.00	Not Applicable
• **Specialist Visits**	$60.00	Not Applicable
• **Urgent Care Facility**	$75.00	Not Applicable
• **Emergency Room (ER)**	$250.00	$250.00
The Emergency Room co-payment is waived if the patient is admitted to the Hospital. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNTS PER CALENDAR YEAR		
Covered Medical Charges	$4,000 single / $8,000 family *Includes deductible and coinsurance*	$5,500 single / $11,000 family *Includes deductible and coinsurance*
Prescription Drugs	$1,700 single / $3,400 family *Not including Specialty Medications*	$1,700 single / $3,400 family *Not including Specialty Medications*
Overall Maximum Out-of-Pocket Amount	$6,350 single / $12,700 family *Includes deductible, copayments, coinsurance and prescription coinsurance*	$7,900 single / $15,800 family *Includes deductible, copayments, coinsurance and prescription coinsurance*
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. *The In and Out-of-Network deductible and Out-of-Pocket maximums accumulate towards each other.*		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: • **Outpatient Mental Health treatment charges** • **Outpatient Substance Abuse treatment charges** • **Inpatient Mental Disorders/Substance Abuse treatment charges if not pre-certified through the Employee Assistance Program (EAP)** • **Bariatric Surgery** • **Cost containment penalties** • **Non-Network Preventive Care** • **Charges above Reasonable & Customary** • **Health Care Charges this Plan does not cover**		
COVERED CHARGES		
HOSPITAL AND FACILITY SERVICES		
When a Network Hospital and Physician have been selected and a Non-Network anesthesiologist, radiologist, pathologist or assistant surgeon is assigned, these providers will be paid at the Network level of benefits, subject to Reasonable and Customary Charges.		

PLAN B	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
ESSENTIAL BENEFITS – MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED	
Note: *The maximums listed are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total that may be split between Network and Non-Network Providers.*		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Each Covered Person	$1250.00	$2,500.00
Per Family Unit	Not Applicable	Not Applicable
CO-PAYMENTS		
• **Physician Visits**	$40.00	Not Applicable
• **Specialist Visits**	$70.00	Not Applicable
• **Urgent Care Facility**	$85.00	Not Applicable
• **Emergency Room (ER)**	$250.00	$250.00
The Emergency Room co-payment is waived if the patient is admitted to the Hospital. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNTS PER CALENDAR YEAR		
Covered Medical Charges	$5,500 single / $11,000 family *Includes deductible and coinsurance*	$8,000 single / $16,000 family *Includes deductible and coinsurance*
Prescription Drugs	$1,700 single / $3,400 family *Not including Specialty Medications*	$1,700 single / $3,400 family *Not including Specialty Medications*
Overall Maximum Out-of-Pocket Amount	$7,700 single / $15,400 family *Includes deductible, copayments, coinsurance and prescription coinsurance*	$10,200 single / $20,400 family *Includes deductible, copayments, coinsurance and prescription coinsurance*
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. *The In and Out-of-Network deductible and Out-of-Pocket maximums accumulate towards each other.*		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: • **Outpatient Mental Health treatment charges** • **Outpatient Substance Abuse treatment charges** • **Inpatient Mental Disorders/Substance Abuse treatment charges if not pre-certified through the Employee Assistance Program (EAP)** • **Bariatric Surgery** • **Cost containment penalties** • **Non-Network Preventive Care** • **Charges above Reasonable & Customary** • **Health Care Charges this Plan does not cover**		
COVERED CHARGES		
HOSPITAL AND FACILITY SERVICES		
When a Network Hospital and Physician have been selected and a Non-Network anesthesiologist, radiologist, pathologist or assistant surgeon is assigned, these providers will be paid at the Network level of benefits, subject to Reasonable and Customary Charges.		