

PLANS & BENEFITS

Use this brochure to compare plans
and choose the one that's best for you.

Benefit highlights

	COPAYMENT		
	Plan 20	Plan 25	Plan 500/1000
FEATURES			
Annual deductible (individual/family)	None		\$500/\$1,000
Annual out-of-pocket maximum (individual/family)	\$2,000/\$6,000	\$3,000/\$9,000	\$3,000/\$6,000
Lifetime benefit maximum	None		
BENEFITS			
Preventive care			
Immunizations	No charge		
Physical exam (primary/specialty)	\$20 copay/\$45 copay	\$25 copay/\$45 copay	
Well-baby visit (under 24 months)	\$20 copay	\$25 copay	
Preventive X-rays and lab tests/MRI, CT, and PET	No charge		
Outpatient services (per visit or procedure)			
Primary care/Specialty care office visit	\$20 copay/\$45 copay	\$25 copay/\$45 copay	\$15 copay/\$25 copay
Most X-rays and lab tests/MRI, CT, and PET	No charge		
Outpatient surgery	\$100 copay	\$250 copay	
Inpatient hospital care			
Physician services, room and board, anesthesia, operating and recovery rooms, laboratory and diagnostic tests, X-rays, drugs, dressings, casts, and respiratory and radiation therapy	\$500 per admission	\$750 per admission	
Maternity coverage			
Physician and hospital services, delivery, and normal nursery care (Separate charges will apply to mother and newborn.)	\$500 per admission	\$750 per admission	
Prenatal visit	No charge		
Emergency and urgent care			
Emergency Department visit (waived if admitted)	\$125 copay		
Urgent care visit	\$45 copay		
Ambulance service	\$125 copay		
Prescription drugs			
Covered formulary drugs	Generic: \$20 copay Brand: \$40 copay	Generic: \$25 copay Brand: \$45 copay (after \$200 drug deductible)	
Other			
Vision services provided by Vision Services Plan (VSP)			Co
Preventive dental care provided by Delta Dental of Ohio			Co

This is only a summary of the most frequently asked-about benefits and their copayments and coinsurance. It is not a contract. For more detailed information, please refer to your *Evidence of Coverage*, which you will receive upon acceptance. For specific questions about coverage, call your broker.

Have a question? We have answers. Call your broker today!

DEDUCTIBLE			HSA-QUALIFIED		
Plan 1000/2000	Plan 1500/3000	Plan 2500/5000	Plan 2500/5000 100/0	Plan 2500/5000 80/20	Plan 5000/10000 100/0
\$1,000/\$2,000	\$1,500/\$3,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$5,000/\$10,000
\$4,000/\$8,000	\$4,000/\$8,000	\$5,000/\$10,000	\$2,500/\$5,000	\$5,000/\$10,000	\$5,000/\$10,000
None			None		
NOT SUBJECT TO DEDUCTIBLE UNLESS OTHERWISE INDICATED					
No charge			No charge		
No charge			\$15 copay		
No charge			\$15 copay		
No charge			No charge		
\$25 copay/\$35 copay			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
20% of eligible charges (after deductible)			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
20% of eligible charges (after deductible)			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
No limits on covered days					
20% of eligible charges (after deductible)			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
20% of eligible charges (after deductible)			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
No charge			No charge (after deductible)		
\$125 copay			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
\$45 copay			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
\$125 copay (after deductible)			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
Generic: \$15 copay/Brand: \$45 copay			No charge (after deductible)	20% of eligible charges (after deductible)	No charge (after deductible)
Covered. See the <i>Dental and Vision</i> brochure for more information.			Not covered		
Covered. See the <i>Dental and Vision</i> brochure for more information.					

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