



Small Group HMO Plans

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			300	3000SX	3001SX	3002SX	3003SX	3502SX
Lifetime Maximum		In-network	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible <i>(up to three family members)</i>	Individual	In-network	\$0	\$0	\$500	\$1,000	\$1,500	\$1,000
	Family	In-network	\$0	\$0	\$1,500	\$3,000	\$4,500	\$3,000
Coinsurance		In-network	100%	100%	100%	100%	100%	80%
Calendar Year Out-of-Pocket Maximum <i>(in addition to the Calendar Year Deductible)</i>	Individual	In-network	\$0	\$0	\$0	\$0	\$0	\$2,000
	Family	In-network	\$0	\$0	\$0	\$0	\$0	\$6,000
Physician Office Visit PCP/SPC <i>(includes x-ray and lab work in office)</i>		In-network copay	\$15/\$20	\$25/\$25	\$25/\$25	\$40/\$40	\$40/\$40	\$25/\$25
Outpatient Diagnostic X-ray/Lab		In-network	100%	100%	100%	100%	100%	80%
Outpatient Surgical Facility/ Ambulatory Surgery Center		In-network	\$100 copay; 100%	\$100 copay; 100%	\$100 copay; 100%	\$100 copay; 100%	\$100 copay; 100%	80%
Physician Outpatient Services <i>(surgeon, anesthesiologist, radiologist, etc.)</i>		In-network	100%	100%	100%	100%	100%	80%
Maternity (physician fee only)	<i>(1st visit only)</i>	In-network copay	\$20	\$25	\$25	\$40	\$40	\$100
Hospital Inpatient Services		In-network	100%	100%	100%	100%	100%	80%
Physician Inpatient Hospital Services		In-network	100%	100%	100%	100%	100%	80%
Physical and Occupational Therapy <i>(combined specialties)</i>		In-network copay	\$20	\$25	\$25	\$40	\$40	\$25
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Chiropractic Care		In-network copay	\$15	\$15	\$15	\$15	\$15	\$15
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Behavioral Health/Substance Abuse	Inpatient	In-network	100%	100%	100%	100%	100%	80%
		Calendar year max	30 days	30 days	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	\$25	\$25	\$25	\$40	\$40	\$25
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Intermediate Level Behavioral Health - Partial Hospitalization Program/Intensive Outpatient		In-network	N/A	N/A	N/A	N/A	N/A	80%
		Calendar year max	N/A	N/A	N/A	N/A	N/A	5 days/visits
Emergency Room	Copay*	In-network	\$100	\$100	\$100	\$100	\$100	\$100
Prescription Drug Copays	Calendar year deductible per member		\$0	\$0	\$0	\$0	\$0	\$0
		Generic Formulary	\$10	\$20	\$20	\$20	\$20	\$15
		Brand Formulary	\$20	\$35	\$35	\$35	\$35	\$30
		Non-Formulary	Not Covered	\$60	\$60	\$60	\$60	\$60
		Mail Order Generic/Brand	\$40/\$40	\$60/\$60	\$60/\$60	\$60/\$60	\$60/\$60	\$30/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details. There are no benefits when services are received at an out-of-network hospital, physician, or other health care provider. * ER copay is waived if admitted to the hospital.



Small Group HMO Plans, *continued*

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			3500SX	3503SX	3802SX	3800SX
Lifetime Maximum		In-network	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible <i>(up to three family members)</i>	Individual	In-network	\$1,000	\$2,000	\$3,000	\$2,000
	Family	In-network	\$3,000	\$6,000	\$9,000	\$6,000
Coinsurance		In-network	80%	80%	70%	70%
Calendar Year Out-of-Pocket Maximum <i>(in addition to the Calendar Year Deductible)</i>	Individual	In-network	\$2,000	\$2,000	\$3,000	\$3,000
	Family	In-network	\$6,000	\$6,000	\$9,000	\$9,000
Physician Office Visit PCP/SPC <i>(includes x-ray and lab work in office)</i>		In-network copay	\$40/\$40	\$25/\$25	\$25/\$25	\$40/\$40
Outpatient Diagnostic X-ray/Lab		In-network	80%	80%	70%	70%
Outpatient Surgical Facility/ Ambulatory Surgery Center		In-network	\$500 copay; 80%	80%	70%	\$1,000 copay; 70%
Physician Outpatient Services <i>(surgeon, anesthesiologist, radiologist, etc.)</i>		In-network	80%	80%	70%	70%
Maternity <i>(physician fee only)</i>	<i>(1st visit only)</i>	In-network copay	\$500	\$100	\$150	\$1,000
Hospital Inpatient Services		In-network	\$500 copay per admission; 80%	80%	70%	\$1,000 copay per admission; 70%
Physician Inpatient Hospital Services		In-network	80%	80%	70%	70%
Physical and Occupational Therapy <i>(combined specialties)</i>		In-network copay	\$40	\$25	\$25	\$40
		Calendar year max	20 visits	20 visits	20 visits	20 visits
Chiropractic Care		In-network copay	\$15	\$15	\$15	\$15
		Calendar year max	20 visits	20 visits	20 visits	20 visits
Behavioral Health/Substance Abuse	Inpatient	In-network	\$500 copay per admission; 80%	80%	70%	\$1,000 copay per admission; 70%
		Calendar year max	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	40	\$25	\$25	\$40
		Calendar year max	20 visits	20 visits	20 visits	20 visits
Intermediate Level Behavioral Health - Partial Hospitalization Program/Intensive Outpatient		In-network	N/A	80%	70%	N/A
		Calendar year max	N/A	5 days/visits	5 days/visits	N/A
Emergency Room	Copay*	In-network	\$150	\$100	\$150	\$150
Prescription Drug Copays	Calendar year deductible per member		\$0	\$0	\$0	\$250
		Generic Formulary	\$20	\$15	\$15	\$20
		Brand Formulary	\$35	\$30	\$30	\$35
		Non-Formulary	\$60	\$60	\$60	Not Covered
		Mail Order Generic/Brand	\$60/\$60	\$30/\$60	\$30/\$60	\$60/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details. There are no benefits when services are received at an out-of-network hospital, physician, or other health care provider. * ER copay is waived if admitted to the hospital.