Medical Plan Options	Pro	Max	Value	Copper	Bronze Pro
Evidence of insurability	**Guaranteed Acceptance**				
PPO Network[7,8]	First Health®		MultiPlan®: PHCS; Practitioner & Ancillary		
Deductible	**In-Network Provider (No Out of Network Coverage)**		**In-Network Provider**		
Individual/ Family	n/a	$2,000/$4,000	$0	$9,200/$18,400	$5,000/$10,000
Out-of-Pocket Max			**In-Network Provider**		
Individual/ Family	$9,200/$18,400	$9,200/$18,400	$9,200/$18,400	$9,200/$18,400	$9,200/$18,400
Medical Services			**In-Network Provider**		
Preventive & Wellness Services *(Non-Hospital Based)*	$0 Copay *(Plan pays 100% of covered preventive and wellness services)*				
Primary Care Office Visit *(Non-Hospital Based)*	$25 Copay *(Combined visit of 5 visits/plan yr)*	$25 Copay per visit *(Deductible does not apply)*	$60 Copay *(Max 6 visits/plan yr)*	$25 Copay per visit	$25 Copay
Specialist Office Visit *(Non-Hospital Based)*		$50 Copay per visit *(Deductible does not apply)*		$45 Copay per visit	$45 Copay
Urgent Care			$50 Copay *(Max 6 visits/plan yr)*	$60 Copay per visit	$60 Copay
Telemedicine Services	$0 Copay[6]		$0 Copay for Virtual Visits	$0 Copay[6]	
Outpatient Diagnostic Services					
Laboratory Services *(Non-Hospital Based)*	$25 Copay *(Combined limit of 5 visits/plan yr)*	$50 Copay per panel tested or image billed *(Deductible does not apply per panel tested)*	$50 Copay *(Combined 3 visits /plan yr)*	After Deductible, plan pays 100%	After Deductible, 20% coinsurance
Radiology *(Non-Hospital Based)*					
CT/MRI/PET Scan *(Non-Hospital Based)*	Not Covered	50% Coinsurance after Deductible[4]	$350 Copay[2,4] *(Max of 1/plan yr)*	After Deductible, plan pays 100%[2,4]	After Deductible, 20% coinsurance[2,4]
Hospitalization and Emergency Services					
Inpatient Hospitalization[2]	Not Covered		$350 Copay per admission[2,4] *(Max 3 days/plan yr)*	After Deductible, plan pays 100%[2]	After Deductible, 20% coinsurance[4]
Inpatient Surgery[2]			Included in Inpatient Hospitalization Copay[2,4] *(Second surgical opinion may be required; Max 2 surgeries/plan yr)*[4]	Included in Inpatient Hospitalization Benefit[4]	
Outpatient Hospital or Free Standing Facility Services and Surgery[2]			$350 Copay[4] *(Max 1 visit/plan yr)*	After Deductible, plan pays 100%[4]	
Emergency Room Services[2]			$350 Copay *(Max 1 visit/plan yr)*		After Deductible, 20% coinsurance
Anesthesia[2]			Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay *(Limited to 2 inpatient and 1 outpatient anesthetic procedures/plan yr)*	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Benefit	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Benefit
Pregnancy Benefits					
Office Visits	$25 Copay *(Considered a Specialist Office Visit.)*	$50 Copay *(Considered a Specialist Office Visit.) (Deductible does not apply)*	Not Covered	$25 Copay per visit	$25 Copay per visit
Professional Services	Not Covered				
Maternity/Childbirth/Delivery[2]				After Deductible, plan pays 100%[4]	After Deductible, 20% coinsurance[4]
Mental Health, Behavioral Health, or Substance Abuse Services					
Inpatient or Partial Day[2]	Not Covered		$350 Copay per admission[1] *(Limited to 3 days/plan yr)*	After Deductible, plan pays 100%[4]	After Deductible, 20% coinsurance[4]
Outpatient Hospital or Free-Standing Facility			$350 Copay[1] *(Limited to 1 visit/plan yr)*		After Deductible, 20% coinsurance
Office Visits	$25 Copay *(Max 5 Visits Per Calendar Year; Combined 5 Visit/plan yr)*	$25 Copay per visit *(Deductible does not apply)*	$60 Copay *(Limited to 6 visits/plan yr)*	$45 Copay	$45 Copay

Medical Plan Options	Pro	Max	Value	Copper	Bronze Pro
Other Services					
Rehabilitation/Habilitation Services *(Physical, Speech, and Occupational)*	Not Covered	$50 Copay per visit *(Combined limit of 20 visits/plan yr.) (Pre-Authorization is required after 6 visits.)*	$50 Copay *(Combined max 6 days/plan yr with physical, speech, & occupational therapies)*	$45 Copay per visit *(Combined limit to 20 Visits/plan yr. Pre-authorization is required after 6 visits.)*	$45 Copay per visit[4] *(Combined limit to 20 visits/plan yr. Pre-authorization is required after 6 visits.)*
Allergy Services[3]		Not Covered	$25 Copay	After Deductible, plan pays 100%	After Deductible, 20% coinsurance *(max 20 visits/plan yr)*
Emergency Medical Transportation[2]			$250 Copay *(By land only; Max 1 transport/plan yr)*		After Deductible, 20% coinsurance
Home Health Care			$25 Copay[4] *(Max 5 visits/plan yr)*	After Deductible, plan pays 100%[4] *(Limited to 60 Visits/plan yr)*	After Deductible, 20% coinsurance[4] *(Max 60 visits/plan yr)*
Second Surgical Opinion			$0 Copay	$0 Copay[4]	$0 Copay[4]
Chiropractic Services			Not Covered	$45 Copay per visit *(Limited to 20 Visits/plan yr)*	$45 Copay per visit *(Limited to 20 visits/plan yr)*
Hospice Care				After Deductible, plan pays 100%[2,4]	After Deductible, 20% coinsurance[2,4]
Prosthetic and Orthotic devices[2]				After Deductible, plan pays 100% *(Limited to a maximum of $6,500/plan yr)*	After Deductible, 20% coinsurance *(max of $6,500/plan yr)*
Skilled Nursing Facility[2]				After Deductible, plan pays 100%[4] *(Limited to 60 days/plan yr)*	After Deductible, 20% coinsurance[4] *(Max 60 visits/plan yr)*
Durable Medical Equipment[2]				After Deductible, plan pays 100%	After Deductible, 20% coinsurance *(Subject to limitations)*
PHARMACY BENEFITS - Included in Medical Plans					
Preventive Prescriptions	No Copay for ACA Compliant covered prescription drugs				
Non-Preventive Prescriptions	20% Coinsurance - Generic Only 12 Prescriptions Maximum 30 day supply Maximum	$20 Copay - Generic only 30 day supply Maximum	Generic - $10 Copay	Not Covered	$10 Copay - Generic only $45 Copay- Preferred Brand $100 Copay- Non-Preferred Brand
PHARMACY BENEFITS - Provided by DataRX[5]					
Prescription Benefit	Not Covered	Copay: $10 Formulary Generic; $50 Formulary Brand Mail Copay: $30 Formulary Generic; $150 Formulary Brand Annual Max: $750 Per Person; $1500 Per Family			Not Covered

Monthly Rates	Pro	Max	Value	Copper	Bronze Pro
Individual	$167.40	$250.92	$537.12	$654.69	$728.23
Individual + Spouse	$249.91	$420.84	$1,046.15	$1,292.24	$1,459.92
Individual + Child	$240.20	$429.26	$917.98	$1,134.56	$1,281.00
Family	$320.48	$635.31	$1,403.66	$1,748.73	$1,993.69

Not available in Alaska, Hawaii, Massachusetts, and New Hampshire.

1. Combined 5 visits per year includes Primary Care Visit to Treat Injury or Illness, Specialist Visit and Urgent Care Visit.
2. Subject to Reference Based Pricing
3. Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit
4. Pre-authorization required.
5. Prescription Benefit is offered through AC&A Limited Partnership by DataRx and is not integrated with the health plan design. The prescription provided by DataRx is not available in NY, SD, and WA. For the Max plan only: In the states noted, $20 co-pay generic only, 30 day supply max.
6. This benefit is offered through AC&A Limited Partnership by a third party and is not integrated with the health plan design.
7. First Health is a brand name of First Health Group Corp., an indirect, wholly-owned subsidiary of Aetna Inc. Provider look-up: http://www.firsthealthlbp.com/
8. To find a provider through the PHCS Practitioner and Ancillary: https://www.multiplan.com/webcenter/portal/ProviderSearch

For additional information reference the Summary Plan Document for a list of services offered In-Network and out-of-Network. Refer to the schedule of benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits, the Schedule of Benefits will govern.
This coverage is available when you join the Limited Partnership. Partners must be active to maintain eligibility.