OPTI-HEALTH 5K

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible:	Participating Providers (In Network)	Out of Network Providers
Individual	$ 5,000	$10000
Family	$10,000	$20000

Out of Pocket Maximum	Participating Providers (In Network)	Out of Network Providers
Individual	$ 7,000	n/a
Family	$14,000	n/a

Schedule of Benefits Below

PHYSCIAN SERVICES

Plan Provisions	Prior Auth Required	Participating Providers (In Network)	Out of Network Providers
		PLAN PAYS	**PLAN PAYS**
Primary Care Office Visit	NO	100% after deductible	60% After Deductible
Specialist office Visit	NO	100% after deductible	60% After Deductible
Other Physician Services performed in the office	NO	100% after deductible	60% After Deductible
Urgent Care	NO	100% after deductible	60% After Deductible
Telemedicine	NO	100%	100%
*Preventive & Wellness Services	NO	100%	40% After Deductible

HOSPITAL/FACILITY SERVICES

Inpatient Hospital	YES	100% after deductible
Inpatient Visit - Physician	NO	Included in Inpatient Hospitalization Copay
Inpatient Surgery -Physician & Anesthesiologist Charges	YES	Included in Inpatient Hospitalization Copay
Outpatient Hospital or Free Standing Facility services & Surgery		100% after deductible
Anesthesia		Included in Inpatient Hospitalization or Outpatient or Free Standing Facility Services & Surgery Copay
ER		100% after deductible

DIAGNOSTIC SERVICES

Laboratory & Minor Diagnostic Services (Laboratory Services, Ultrasound, Bone Density, Echography, Etc.)	NO	100% after deductible	60% after deductible
Radiology	NO	100% after deductible	60% after deductible
CT/MRI/MRA/PET Scan	Yes	100% after deductible	100% less $400 copay

PREGNANCY BENEFITS

Professional Services	NO	100% after deductible	60% after Deductible
Maternity/childbirth & Delivery considered an Inpatient-Hospital Stay	YES	100% after deductible	100% less $400 Co pay

OTHER SERVICES

Dialysis	yes	100% after deductible	Not Covered
Colonoscopy	NO	100% after deductible	Not Covered
Chiropractic Car	NO	Not Covered	Not Covered
Durable Medical Equipment	NO	100% after deductible	Not Covered
Emergency Medical Transportation	NO	100% after deductible	100% less $400 Co pay
Home Health Care (limit 20 visits per plan year)	YES	100% after deductible	100% less $25 Co pay
Second Surgical Opinion	YES	100% after deductible	$0
Hospice	NO	100% after deductible	Not Covered
Rehabilitation/Habilitation Services (Physical, Limited to 5 visits per plan year	NO	100% after deductible	Not Covered
Transplants	NO	100% after deductible	Not Covered
Treatment for Chemical Abuse & Dependency (In-Patient)	No	100% after deductible	Not Covered
Treatment for Chemical Abuse & Dependency (Out-Patient)	NO	100% after deductible	Not covered
Chemotherapy	Yes	100% after deductible	Not covered

PRESCRIPTIONS

Pharmacy Retail up to 30-day Supply (Specialty drugs and compounds are not covered)		Generic: $10 Co pay Preferred: $40 Co pay Non-Preferred $80 Co pay	Not covered
Pharmacy Mail Order 90-day supply		Generic: $30 Co pay Preferred: $120 Co pay Non-Preferred $240 Co pay	Not Covered
Specialty Drugs		Not covered	Not Covered

***not covered in hospital.**

A detailed SPD (summary plan description) is included with your introduction package.

To enroll on-line go to: **Healthapplication.org**

Have Questions? Need Assistance? 631-424-2400