Comprehensive Summary of Benefits (Effective January 1, 2023)

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
Annual Deductible Asterisk * - Indicates when the annual deductible applies	$300 Per Person $900 Per Family	$300 Per Person $900 Per Family
Annual Co-payment Maximum	$3,000 Per Person, Maximum $9,000 Per Family	
Lifetime Maximum	Unlimited	
Dependent Coverage	To age 26	
MEDICAL SERVICES* Member Pays		
PHYSICIAN SERVICES		
Office Visits (including Specialist)	$17 co-payment	30%
Hospital Visits	$17 co-payment	30%
Emergency Room Visits	$17 co-payment	$17 co-payment
Urgent Care	$17 co-payment	30%
Immunizations	No co-payment	30%
HOSPITAL SERVICES		
Room & Care – semi-private room rate; unlimited number of days	20%	30%
Intensive Care Unit, Coronary Care Unit, Ancillary Services, Inpatient Laboratory and X-ray	20%	30%
Emergency Room Facility	20%	20%
Ambulatory Surgical Center	20%	30%
Maternity Services; semi-private room rate	20%	30%
Inpatient Surgery	20% for cutting	30% for cutting
	20% for non-cutting	30% for non-cutting
Inpatient Anesthesiologist	20%	30%
OUTPATIENT LABORATORY & X-RAY SERVICES		
Outpatient X-ray films, diagnostic services	20%	30%
Radiotherapy for malignancies and non-malignancies	20%	30%
MENTAL HEALTH SERVICES* Member Pays		
Inpatient Hospital & Facility Services; semi-private room rate	20%	30%
Inpatient Psychiatrist & Psychologist Services	No co-payment	30%
Inpatient Psychological Testing	20%	30%
Outpatient Psychiatrist & Psychologist Services	$17 co-payment	30%
Outpatient Psychological Testing	20%	30%
OTHER SERVICES* Member Pays		
Ambulance	20%	30%
Air Ambulance (Limited to State of Hawaii)	20%	30%
Allergy Testing	20%	30%
Appliances & Equipment	20%	30%
Applied Behavior Analysis Therapy of Autism Spectrum Disorder	$17 co-payment	30%
Blood and Blood Products	20%	30%
Chemotherapy	20%	30%
Contraceptives (Contraceptive IUD, Implants and Injectables)	No co-payment	50% No Deductible Applied
Dialysis and Supplies	20%	30%
Evaluations for the Use of Hearing Aids	20%	30%
Gender Identity Services	20%	30%
Nutritional Counseling for Treatment of Eating Disorders	$17 co-payment	30%
Orthodontic Treatment of Orofacial Anomalies	No co-payment	No co-payment No Deductible Applied
Organ Donor Services	20%	30%
Outpatient Injections	20%	30%
Physical/Occupational/Speech Therapy	20% outpatient / inpatient	30% outpatient / inpatient
Supportive Care	No co-payment	Not covered

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
BENEFITS FOR CHILDREN Member Pays		
Newborn Circumcision	20% after annual deductible	30% after annual deductible
Well Child Care Office Visits (Up until age 5)	No co-payment	30%
Well Child Care Office Visits (Ages 6 through 18)	20% Annual deductible does not apply	30%
Well Child Care Immunization	No co-payment	No co-payment
Well Child Care Lab Tests	No co-payment	30%
Student Physical Exam: Beneficiaries six (6) through eighteen (18) years of age are entitled to one (1) Student Physical Exam per calendar year as required by school. Student Physical Exams are not subject to the Annual Deductible. Member pays 20% Participating Providers / 30% Non-Participating Providers		
PREVENTIVE CARE Member Pays		
Preventive Care Services as required by the Affordable Care Act	No co-payment	30% after annual deductible
Pap Smears (Screenings – One every 3 calendar years [CY) ages 21 through 65)	No co-payment	30% after annual deductible
Mammography 1 per CY age ≥ 40)	No co-payment	30%
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	No co-payment	30% after annual deductible
ACUPUNCTURE / CHIROPRACTIC SERVICES Member Pays		
There is a combined calendar year benefit maximum of $400.00 paid by the Plan for Acupuncture and Chiropractic Services.		
Acupuncture; Chiropractic Spinal Manipulation	$15 co-payment per visit	$25 co-payment per visit
Chiropractic: Office Visit (Examination), Radiology (Imaging), Physical Therapy	$10 co-payment per visit	$15 co-payment per visit
VISION CARE SERVICES Plan Pays		
VISION EXAM – One per calendar year	100% of eligible charge after $10 annual deductible	Up to $40
LENSES	Only one of the following per calendar year	
Single	100% of eligible charge after $10 annual deductible	Up to $16
Multifocal	100% of eligible charge after $10 annual deductible	Up to $25
Contact Lenses	Up to $130 of eligible charge after $25 annual deductible	Up to $50
FRAMES – One frame every other calendar year	100% of eligible charge after $15 annual deductible (1)	Up to $12
(1) Frames must be chosen from a group selected by the provider. If the member chooses a frame outside of the group, the member will have to pay any difference between the plan's allowance and the provider's charge for the frames. If the member replaces only the lenses of his/her glasses, the allowance for frames cannot be applied to the cost of the lenses.		
PHARMACY BENEFITS Member Pays		
Annual Co-payment Maximum (1)	$4,850 Per Person, $7,200 Per Family	
Times and Preferred Network Pharmacies Prescription Drugs (2) (30 day supply)	Generic: $7 co-pay Preferred Brand:$20 co-pay Non-Preferred Brand: $50 co-pay	Generic: $60 co-pay Preferred Brand: $90 co-pay Non-Preferred Brand: $125 co-pay
Times, Preferred Network Pharmacies and Mail Order (2) (31-90 day supply)	Generic: $10 co-pay Preferred Brand: $25 co-pay Non-Preferred Brand: $60 co-pay	Member pays 100% of charges
All Other Non-Preferred Pharmacies in the Synergy MedSolutions Network (30 day supply ONLY)	$60 co-pay per Generic $90 co-pay per Preferred Brand $125 co-pay per Non-Preferred Brand	Member pays 100% of charges Member pays 100% of charges Member pays 100% of charges
Specialty Drugs (3) (4) Must be dispensed through Pharmacare	$100 co-pay for a 30 day supply If the cost of the covered Specialty Drug exceeds $10,000, the co-pay is 20%, based on approved prior authorization.	Member pays 100% of charges

(1) You will not pay more than the annual co-payment maximum in a calendar year.
(2) If the cost of the drug exceeds $5,000, the co-pay is 20%, based on approved prior authorization.
(3) All Specialty Drugs must be dispensed through Pharmacare. Step Therapy program applies.
(4) There will be a once per lifetime limitation on Hepatitis C treatment

All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.

All plan benefits shown as a percentage of Eligible Charge. See the Plan Document for a full description of benefits. *Updated 12/7/22*