Enhanced Summary of Benefits (Effective January 1, 2023)

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
Annual Deductible	$100 Per Person/$300 Per Family	$100 Per Person
	For Other Services*	$300 Per Family
Annual Co-payment Maximum	$2,500 Per Person, Maximum $7,500 Per Family	
Lifetime Maximum	None	
Dependent Coverage	To age 26	
MEDICAL SERVICES Member Pays		
PHYSICIAN SERVICES		
Office Visits (including Specialist)	$10 co-payment	30% after annual deductible
Hospital Visits	10%	30% after annual deductible
Emergency Room Visits	10%	10%
Urgent Care	10%	30% after annual deductible
Immunizations	No co-payment	30% after annual deductible
HOSPITAL SERVICES		
Room & Care – semi-private room rate; unlimited number of days	10%	30% after annual deductible
Intensive Care Unit, Coronary Care Unit, Ancillary Services, Inpatient Laboratory and X-ray	10%	30% after annual deductible
Emergency Room Facility	20%	20%
Ambulatory Surgical Center	$50 co-payment	30% after annual deductible
Maternity Services; semi-private room rate	10%	30% after annual deductible
Inpatient Surgery	10% for cutting	30% after annual deductible
	20% for non-cutting	
Inpatient Anesthesiologist	10%	30% after annual deductible
OUTPATIENT LABORATORY & X-RAY SERVICES		
Outpatient X-ray films, diagnostic services	20%	30% after annual deductible
Radiotherapy for malignancies and non-malignancies	20%	30% after annual deductible
MENTAL HEALTH SERVICES Member Pays		
Inpatient Hospital & Facility Services; semi-private room rate	10%	30% after annual deductible
Inpatient Psychiatrist & Psychologist Services	10%	30% after annual deductible
Inpatient Psychological Testing	10%	30% after annual deductible
Outpatient Psychiatrist & Psychologist Services	10%	30% after annual deductible
Outpatient Psychological Testing	20%	20% after annual deductible
OTHER SERVICES* Member Pays		
OTHER SERVICES*	* All benefits payable after application of annual deductible	
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	20%	30%
Blood and Blood Products	20%	30%
Chemotherapy	20%	30%
Contraceptives (Contraceptive IUD, Implants and Injectables)	No co-payment	30%
Dialysis and Supplies	20%	30%
Evaluations for the Use of Hearing Aids	20%	30%
Gender Identity Services	20%	30%
Habilitative Services	20%	30%
Nutritional Counseling for Treatment of Eating Disorders	10%	30%
Orthodontic Treatment of Orofacial Anomalies	20%	30%
Organ Donor Services	20%	30%
Outpatient Injections	20%	30%
Physical/Occupational/Speech Therapy	20% Outpatient / 10% Inpatient No Deductible Applied	30%

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
Supportive Care	20%	30%
BENEFITS FOR CHILDREN Member Pays		
Newborn Circumcision	10%	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)	No co-payment	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. 90% Participating Providers / 70% 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%
Mammography 1 per CY age ≥ 40)	No co-payment	30%
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	No co-payment	30%
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 (2) (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
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 12/07/22*		