Plan Name	Select 500	Select 750	Select 1500
	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.
100% Benefits ***HDHP must pay deductible***	**100% Benefits Available:** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***	**100% Benefits Available:** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***	**100% Benefits Available:** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***
Individual Deductible	**$500**	**$750**	**$1,500**
Individual out-of-pocket Maximum *Includes deductibles and copays*	**$3,500**	**$3,750**	**$4,500**
Family Deductible	3 individual deductibles must be satisfied per family.	3 individual deductibles must be satisfied per family.	2 individual deductibles must be satisfied per family.
Family out-of-pocket Maximum *Includes deductibles and copays. Individual family member is embedded*	**$10,500**	**$11,250**	**$10,500**
Coinsurance Percentage *Unless another percentage is stated*	The Plan pays 80%, the participant pays 20%	The Plan pays 80%, the participant pays 20%	The Plan pays 80%, the participant pays 20%
Physician's Office Visit Copay	**$15**	**$25**	**$25**
Urgent Care Visit Copay	**$15**	**$25**	**$25**
Emergency Room *Charges may be waived if accident or life threatening*	**$100** Then subject to deductible and coinsurance.	**$100** Then subject to deductible and coinsurance.	**$100** Then subject to deductible and coinsurance.
Surgical Procedures *Covered at 100% when a Premier Provider is used*	**$300** Then subject to deductible and coinsurance.	**$300** Then subject to deductible and coinsurance.	**$300** Then subject to deductible and coinsurance.
Pre-Certification Requirement	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.
Laboratory Copay *Covered at 100% if LabCard provider is used*	The Plan pays 80%, the participant pays 20%. Deductible waived.	The Plan pays 80%, the participant pays 20%. Deductible waived.	The Plan pays 80%, the participant pays 20%. Deductible waived.
Diagnostic Imaging *Covered at 100% if onecallcare or Premier Provider is used*	After deductible, the Plan pays 80%, the participant pays 20%	After deductible, the Plan pays 80%, the participant pays 20%	After deductible, the Plan pays 80%, the participant pays 20%
Pharmacy General Benefits *In-network only* *Walgreens is non-covered*	**Generic - $10** **Name Brand $45** *If you select a brand name drug when a generic drug is available, you pay the co-pay PLUS the difference in cost between the generic and the brand name drug. Walgreens is non-covered.*	**Generic - $10** **Name Brand $45** *If you select a brand name drug when a generic drug is available, you pay the co-pay PLUS the difference in cost between the generic and the brand name drug. Walgreens is non-covered.*	**Generic - $10** **Name Brand $45** *If you select a brand name drug when a generic drug is available, you pay the co-pay PLUS the difference in cost between the generic and the brand name drug. Walgreens is non-covered.*
Pharmacy Therapeutic Alternatives *Specific Name Brand RX* *In-network only* *Walgreens is non-covered*	**50%** *There are specific Name Brand prescriptions that have a therapeutic alternative. If you choose one of these drugs, the co-pay will be 50% of the drug cost. Refer to the Therapeutic Alternative Drug list at advantagehealthplans.com*	**50%** *There are specific Name Brand prescriptions that have a therapeutic alternative. If you choose one of these drugs, the co-pay will be 50% of the drug cost. Refer to the Therapeutic Alternative Drug list at advantagehealthplans.com*	**50%** *There are specific Name Brand prescriptions that have a therapeutic alternative. If you choose one of these drugs, the co-pay will be 50% of the drug cost. Refer to the Therapeutic Alternative Drug list at advantagehealthplans.com*
Pharmacy OTC Benefit *100% Over the Counter Benefit* *In-network only* *Walgreens is non-covered*	**$0** *Certain over the counter drugs at NO COST. 102 day supply of an OTC drug when your physician prescribes an OTC drug in lieu of a prescription drug. Refer to the OTC Drug List at advantagehealthplans.com*	**$0** *Certain over the counter drugs at NO COST. 102 day supply of an OTC drug when your physician prescribes an OTC drug in lieu of a prescription drug. Refer to the OTC Drug List at advantagehealthplans.com*	**$0** *Certain over the counter drugs at NO COST. 102 day supply of an OTC drug when your physician prescribes an OTC drug in lieu of a prescription drug. Refer to the OTC Drug List at advantagehealthplans.com*
Pharmacy Specialty Benefits *Specialty Drugs* *Specialty Pharmacy Mandatory*	**$150 copay** *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*	**$150 copay** *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*	**$150 copay** *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*
Pharmacy Maintenance Benefits *Maintenance Drugs* *In-network only* *Walgreens is non-covered*	**Generic - $10** **Name Brand - $90** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available at your local pharmacy.*	**Generic - $10** **Name Brand - $90** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available at your local pharmacy.*	**Generic - $10** **Name Brand - $90** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available at your local pharmacy.*

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Plan Name	Value 750	Value 1500	Value 2000
	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.
100% Benefits ***HDHP must pay deductible***	**100% Benefits Available:** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***	**100% Benefits Available:** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***	**100% Benefits Available:** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***
Individual Deductible	**$750**	**$1,500**	**$2,000**
Individual out-of-pocket Maximum *Includes deductibles and copays*	**$5,750**	**$6,500**	**$7,000**
Family Deductible	2 individual deductibles must be satisfied per family.	2 individual deductibles must be satisfied per family.	2 individual deductibles must be satisfied per family.
Family out-of-pocket Maximum *Includes deductibles and copays. Individual family member is embedded*	**$11,500**	**$13,000**	**$14,000**
Coinsurance Percentage *Unless another percentage is stated*	The Plan pays 70%, the participant pays 30%	The Plan pays 70%, the participant pays 30%	The Plan pays 70%, the participant pays 30%
Physician's Office Visit Copay	**$35**	**$35**	**$35**
Urgent Care Visit Copay	**$35**	**$35**	**$35**
Emergency Room *Charges may be waived if accident or life threatening*	**$200** Then subject to deductible and coinsurance.	**$200** Then subject to deductible and coinsurance.	**$200** Then subject to deductible and coinsurance.
Surgical Procedures *Covered at 100% when a Premier Provider is used*	**$300** Then subject to deductible and coinsurance.	**$300** Then subject to deductible and coinsurance.	**$300** Then subject to deductible and coinsurance.
Pre-Certification Requirement	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.
Laboratory Copay *Covered at 100% if LabCard provider is used*	The Plan pays 70%, the participant pays 30%. Deductible waived.	The Plan pays 70%, the participant pays 30%. Deductible waived.	The Plan pays 70%, the participant pays 30%. Deductible waived.
Diagnostic Imaging *Covered at 100% if onecallcare or Premier Provider is used*	After deductible, the Plan pays 70%, the participant pays 30%	The Plan pays 70%, the participant pays 30%.	After deductible, the Plan pays 70%, the participant pays 30%
Pharmacy General Benefits *In-network only* *Walgreens is non-covered*	**Generic - $15** **Name Brand $55** *If you select a brand name drug when a generic drug is available, you pay the co-pay PLUS the difference in cost between the generic and the brand name drug. Walgreens is non-covered.*	**Generic - $15** **Name Brand $55** *If you select a brand name drug when a generic drug is available, you pay the co-pay PLUS the difference in cost between the generic and the brand name drug. Walgreens is non-covered.*	**Generic - $15** **Name Brand $55** *If you select a brand name drug when a generic drug is available, you pay the co-pay PLUS the difference in cost between the generic and the brand name drug. Walgreens is non-covered.*
Pharmacy Therapeutic Alternatives *Specific Name Brand RX* *In-network only* *Walgreens is non-covered*	**50%** *There are specific Name Brand prescriptions that have a therapeutic alternative. If you choose one of these drugs, the co-pay will be 50% of the drug cost. Refer to the Therapeutic Alternative Drug list at advantagehealthplans.com*	**50%** *There are specific Name Brand prescriptions that have a therapeutic alternative. If you choose one of these drugs, the co-pay will be 50% of the drug cost. Refer to the Therapeutic Alternative Drug list at advantagehealthplans.com*	**50%** *There are specific Name Brand prescriptions that have a therapeutic alternative. If you choose one of these drugs, the co-pay will be 50% of the drug cost. Refer to the Therapeutic Alternative Drug list at advantagehealthplans.com*
Pharmacy OTC Benefit *100% Over the Counter Benefit* *In-network only* *Walgreens is non-covered*	**$0** *Certain over the counter drugs at NO COST. 102 day supply of an OTC drug when your physician prescribes an OTC drug in lieu of a prescription drug. Refer to the OTC Drug List at advantagehealthplans.com*	**$0** *Certain over the counter drugs at NO COST. 102 day supply of an OTC drug when your physician prescribes an OTC drug in lieu of a prescription drug. Refer to the OTC Drug List at advantagehealthplans.com*	**$0** *Certain over the counter drugs at NO COST. 102 day supply of an OTC drug when your physician prescribes an OTC drug in lieu of a prescription drug. Refer to the OTC Drug List at advantagehealthplans.com*
Pharmacy Specialty Benefits *Specialty Drugs* *Specialty Pharmacy Mandatory*	**$150 copay** *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*	**$150 copay** *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*	**$150 copay** *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*
Pharmacy Maintenance Benefits *Maintenance Drugs* *In-network only* *Walgreens is non-covered*	**Generic - $30** **Name Brand - $110** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available through Mail Order.*	**Generic - $30** **Name Brand - $110** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available through Mail Order.*	**Generic - $30** **Name Brand - $110** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available through Mail Order.*

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Plan Name	HDHP 2500	Consumer Plan 3500 Plus	Minimum Value Plan (MVP)
	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.	In-network and out-of-network benefits are the same for medical services unless otherwise noted. Out-of-network claims are held to a120% of Medicare for physician and 150% of Medicare for facility/hospital. Out-of-network pharmacy is not covered. Out-of-network preventive services not covered at 100% and may have copays or coinsurance.
100% Benefits ***HDHP must pay deductible***	**100% Benefits Available *after Deductible*** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***	**100% Benefits Available:** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***	**100% Benefits Available:** **Advantage Premier Providers** **LabCard** **onecallcare Management** **Over the Counter Medications** ***Call us or visit advantagehealthplans.com to learn more!***
Individual Deductible	**$2,500**	**$3,500**	**$7,150**
Individual out-of-pocket Maximum *Includes deductibles and copays*	**$5,000**	**$7,150**	**$7,150**
Family Deductible	$5,000 *Embedded deductible for a family member is $2,600*	$7,000 aggregate *Embedded deductible for family member is $3,500*	$14,300 aggregate *Embedded deductible for family member is $7,150*
Family out-of-pocket Maximum *Includes deductibles and copays. Individual family member is embedded*	**$10,000**	**$14,300 aggregate**	**$14,300 aggregate**
Coinsurance Percentage *Unless another percentage is stated*	The Plan pays 80%, the participant pays 20%	The Plan pays 80%, the participant pays 20%	After deductible, the Plan pays 100% of covered charges.
Physician's Office Visit Copay	**After deductible, the Plan pays 80%, the participant pays 20%**	**$25**	After deductible, the Plan pays 100% of covered charges.
Urgent Care Visit Copay	**After deductible, the Plan pays 80%, the participant pays 20%**	**$25**	After deductible, the Plan pays 100% of covered charges.
Emergency Room *Charges may be waived if accident or life threatening*	After deductible, the Plan pays 80%, the participant pays 20%.	**$100** Then subject to deductible and coinsurance.	After deductible, the Plan pays 100% of covered charges.
Surgical Procedures *Covered at 100% when a Premier Provider is used*	After deductible, the Plan pays 80%, the participant pays 20%. After deductible, 100% if a Premier Provider is used.	**$300** Then subject to deductible and coinsurance.	After deductible, the Plan pays 100% of covered charges.
Pre-Certification Requirement	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required. This is the patient's responsibility.
Laboratory Copay *Covered at 100% if LabCard provider is used*	After deductible, the Plan pays 80%, the participant pays 20%.	After deductible, the Plan pays 80%, the participant pays 20%.	After deductible, the Plan pays 100% of covered charges.
Diagnostic Imaging *Covered at 100% if onecallcare or Premier Provider is used*	After deductible, the Plan pays 80%, the participant pays 20%	After deductible, the Plan pays 80%, the participant pays 20%	After deductible, the Plan pays 100% of covered charges.
Pharmacy General Benefits *In-network only* *Walgreens is non-covered*	**Generic - After deductible,10% co-pay** **Name Brand - After deductible, 20% co-pay** *If you select a brand name drug when a generic drug is available, you pay the co-pay PLUS the difference in cost between the generic and the brand name drug. Walgreens is non-covered.*	**Generic - $10** **Name Brand $45** *If you select a brand name drug when a generic drug is available, you pay the co-pay PLUS the difference in cost between the generic and the brand name drug. Walgreens is non-covered.*	After deductible, the Plan pays 100% of covered charges. *Walgreens is non-covered.*
Pharmacy Therapeutic Alternatives *Specific Name Brand RX* *In-network only* *Walgreens is non-covered*	**After deductible, 50% copay** *There are specific Name Brand prescriptions that have a therapeutic alternative. If you choose one of these drugs, the co-pay will be 50% of the drug cost. Refer to the Therapeutic Alternative Drug list at advantagehealthplans.com*	**50%** *There are specific Name Brand prescriptions that have a therapeutic alternative. If you choose one of these drugs, the co-pay will be 50% of the drug cost. Refer to the Therapeutic Alternative Drug list at advantagehealthplans.com*	After deductible, the Plan pays 100% of covered charges.
Pharmacy OTC Benefit *100% Over the Counter Benefit* *In-network only* *Walgreens is non-covered*	**After deductible, $0 copay** *AFTER your deductible is met, you can receive a 102 day supply of an OTC drug for $0 when your physician prescribes an OTC drug in lieu of a prescription drug. Refer to the OTC Drug List at www.advantagehealthplans.com*	**$0** *Certain over the counter drugs at NO COST. 102 day supply of an OTC drug when your physician prescribes an OTC drug in lieu of a prescription drug. Refer to the OTC Drug List at advantagehealthplans.com*	After deductible, the Plan pays 100% of covered charges.
Pharmacy Specialty Benefits *Specialty Drugs* *Specialty Pharmacy Mandatory*	**After deductible is met, 10% Generic co-pay, 20% Name Brand**. *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*	**$150 copay** *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*	**After deductible, the Plan pays 100% of covered charges.** *Specialty Pharmacy must be used.* *Contact Script Care Specialty Pharmacy at (866) 443-1991*
Pharmacy Maintenance Benefits *Maintenance Drugs* *In-network only* *Walgreens is non-covered*	**After deductible is met, 10% Generic co-pay, 20% Name Brand.** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available at your local pharmacy.*	**Generic - $10** **Name Brand - $90** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available at your local pharmacy.*	**After deductible, the Plan pays 100% of covered charges.** *A 102 day supply of covered drugs that appear on the Maintenance Drug list is available at your local pharmacy.*

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