



BENEFIT PROVISIONS	VALUE PLANS							
	Value 750		Value 1000		Value 1500		Value 2000	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Individual Deductible</b>	\$750	\$1,500	\$1,000	\$2,000	\$1,500	\$3,000	\$2,000	\$4,000
<b>Family Deductible Limit</b>	\$2,250	\$4,500	\$3,000	\$6,000	\$4,500	\$9,000	\$6,000	\$12,000
	Family Deductible - 3 individual deductibles must be satisfied per family. When an individual's deductible is met, benefits begin for that individual regardless of whether the Family Maximum has been met.							
<b>Lifetime/Annual Maximum</b>	\$3,000,000/\$2,000,000							
<b>ER Deductible</b>	\$200 per occurrence, then deductible and coinsurance. ER Deductible is waived for accidents, life threatening conditions, or if the patient is admitted.							
<b>Surgical Procedures</b>	\$300 per occurrence, then deductible and coinsurance. Any inpatient or outpatient surgical procedure done outside a physician's office is subject to this deductible.							
<b>Physician's Office Visit</b>	\$35 co-pay; then 100%.	Subject to deductible and coinsurance	\$35 co-pay; then 100%.	Subject to deductible and coinsurance	\$35 co-pay; then 100%.	Subject to deductible and coinsurance	\$35 co-pay; then 100%.	Subject to deductible and coinsurance
<b>Individual Out of Pocket Maximum</b>	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000
<b>Family Out of Pocket Maximum</b>	3 family members EXCLUDES deductibles and co-pays.							
<b>Coinsurance Percentage</b>	70% In Network - 50% Out of Network Unless another coinsurance percentage is specifically stated							
<b>Pre-Certification Requirement</b>	Pre-certification of all in-patient confinements, out-patient surgeries, and sleep studies is required.							
<b>Hospital Room Allowance</b>	Subject to deductible and coinsurance Hospital Room Allowance - Semi-private / ICU Room Allowance - 3x Semi-private							
<b>Manipulative Therapy</b>	\$35 Office Visit co-pay, then 100% up to \$75 per visit, 26 visits per year	Not covered	\$35 Office Visit co-pay, then 100% up to \$75 per visit, 26 visits per year	Not covered	\$35 Office Visit co-pay, then 100% up to \$75 per visit, 26 visits per year	Not covered	\$35 Office Visit co-pay, then 100% up to \$75 per visit, 26 visits per year	Not covered
<b>Annual Mammogram</b>	100% up to \$150. Then subject to deductible and coinsurance.							
<b>Routine Colonoscopy</b>	Participants over 50 years old, once every 5 years. \$35 co-pay, then 100%.	Not covered	Participants over 50 years old, once every 5 years. \$35 co-pay, then 100%.	Not covered	Participants over 50 years old, once every 5 years. \$35 co-pay, then 100%.	Not covered	Participants over 50 years old, once every 5 years. \$35 co-pay, then 100%.	Not covered
<b>Wellness Benefit</b>	\$35 co-pay, then 100% up to \$500 per person per year	Not covered	\$35 co-pay, then 100% up to \$500 per person per year	Not covered	\$35 co-pay, then 100% up to \$500 per person per year	Not covered	\$35 co-pay, then 100% up to \$500 per person per year	Not covered

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Special Benefits	<p style="text-align: center;"><b>ALL VALUE PLANS IN NETWORK</b></p> <p style="text-align: center;">2nd Surgical Opinions (optional) Pre-Admission Testing Mandated Childhood Immunizations - 100% Out-Patient Labwork - 70% when a network provider is used</p>							
Mental and Nervous Benefit	<p style="text-align: center;"><b>ALL VALUE PLANS IN AND OUT OF NETWORK</b></p> <p style="text-align: center;">Subject to deductible In-patient - 30 days per year at 50% Out-patient - 1 visit per day, 50% up to \$50 per visit</p>							
Alcohol and Substance Abuse	<p style="text-align: center;"><b>ALL VALUE PLANS IN AND OUT OF NETWORK</b></p> <p style="text-align: center;">Subject to deductible In-patient - 30 days per year at 50% Out-patient - 1 visit per day, 50% up to \$50 per visit, \$1,000 per calendar year LIFETIME MAXIMUM \$10,000</p>							
Pharmacy Benefits	<p style="text-align: center;"><b>ALL VALUE PLANS IN NETWORK</b></p> <p style="text-align: center;"><b>BASIC PHARMACY BENEFIT</b></p> <p style="text-align: center;">You pay a co-pay per prescription as follows:</p> <p style="text-align: center;">Generic - \$15 Brand Name - \$55</p> <p style="text-align: center;"><i>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.</i></p> <p style="text-align: center;"><b>SPECIFIC NAME BRAND PRESCRIPTIONS</b></p> <p style="text-align: center;"><b>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. The list of these drugs is available on our website.</b></p> <p style="text-align: center;"><b>OVER THE COUNTER (OTC) BENEFIT</b></p> <p style="text-align: center;">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 <a href="http://www.advantagehealthplans.com">www.advantagehealthplans.com</a></p> <p style="text-align: center;"><b>MAINTENANCE DRUG BENEFIT</b></p> <p>A 3-month supply of covered drugs that appear on the Maintenance Drug list is available only by mail order.. This benefit requires a prescription specifying that the entire 3-month supply is to be dispensed at one time. A one-month prescription</p> <p style="text-align: center;">Generic - You pay TWO co-pay Any Brand Name - You pay TWO co-pays</p> <p style="text-align: center;">Refer to the Maintenance Drug List at <a href="http://www.advantagehealthplans.com">www.advantagehealthplans.com</a></p>							

**Advantage Health Plans  
OPTIONAL DENTAL BENEFITS**

BENEFIT PROVISIONS	ADVANTAGE DENTAL
<b>Annual Maximum</b>	\$1,500
<b>Calendar Year Deductible</b>	\$50
Applies to Basic and Major Services combined	3 per family
<b>Preventative Services</b>	100% of scheduled amount
Deductible waived - No waiting period	2 per year
<b>Basic &amp; Restorative Services</b>	80%
Fillings, Extractions, Endodontics, Periodontics No waiting period	
<b>Major Services</b>	60%
Inlays, Crowns, Etc. - No waiting period	
<b>Orthodontia -Dependant Children Only</b>	50%
No waiting period	Lifetime Maximum - \$500

\*This comparison is for review purposes only and is not a guarantee of benefits. Please refer to your Summary Plan Description.

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