



## TRADITIONAL COPAY PLANS – WELLPATH SELECT, INC.

In-Network Benefits	Plan 3A	Plan 5A	Plan 6A	Plan 7A
<i>Benefit year deductible must be satisfied before coinsurance applies. Benefits listed with a copay are not subject to deductible unless noted.</i>				
<b>Maximum Lifetime Benefit</b> (per member)	Unlimited			
<b>Deductible</b> (per member or three times per family)	\$1,000	\$500	\$1,000	\$2,500
<b>Coinsurance</b> (Plan pays in-network)	100%	80% after Deductible		
<b>Coinsurance Maximum</b> (in-network after deductible, per benefit year, maximum two times the individual coinsurance maximum)	Not Applicable	\$2,000		
<b>Physician Office Visit (PCP)</b> General Physician, Family Practitioner, Pediatrician or Internist; Includes Office Visits, Simple Labs and X-rays (when performed in office).	\$15 Copay			
<b>Specialty Physician Office Services</b> Includes Simple Labs and X-rays (when performed in office), Allergy Testing and Treatments	\$30 Copay			
<b>Preventive Services</b> Includes Pap Smears, Mammograms, PSA Testing, Colorectal Cancer Screening, Routine Child/Adult Well-Care Exams and immunizations.	WellPath pays 100%			
<b>Urgent Care Facility Services</b>	\$30 Copay			
<b>Emergency Room Services</b> (waived if admitted to the hospital)	\$250 Copay			
<b>Inpatient and Outpatient Hospital Services</b> Includes X-ray, Lab, Diagnostic Services, MRI, CT and PET scans, Other Nuclear Med, Surgery, Anesthesia, Chemotherapy, Radiation Treatment	WellPath pays 100% after Deductible	WellPath pays 80% after Deductible		
<b>Vision Exam</b> (every 12 months)	\$15 Copay for in-network routine vision exam			
<b>Chiropractic Services</b> (20 visits per benefit year)	\$15 Copay			
<b>Prescription Drug Coverage</b>	<i>Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90-day supply.</i>			
<b>Prescription Deductible</b>	Not Applicable			
<b>Tier 1: Preferred Generic</b>	\$10			
<b>Tier 2: Formulary Brand</b>	\$35			
<b>Tier 3: Non-Formulary</b>	\$50			
<b>Tier 4: Self-Administered Injectable Drugs and some Specialty Medications</b>	10%			
Out-of-Network Benefits	Plan 3A	Plan 5A	Plan 6A	Plan 7A
<b>Deductible</b> (per member, maximum three times per family)	\$2,000	\$1,000	\$2,000	\$5,000
<b>Coinsurance</b>	WellPath pays 70% after Deductible			
<b>Coinsurance Maximum</b> (per member, maximum two times in-network)	Not Applicable	\$4,000		
<b>Physician Office Services, Urgent Care Facility Services, Inpatient and Outpatient Hospital Services</b>	WellPath pays 70% after Deductible			
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## VALUE COPAY PLANS – WELLPATH SELECT, INC.

In-Network Benefits	Plan 9A	Plan 10A	Plan 11A	Plan 12A	Plan 14A	Plan 16A
<i>Benefit year deductible must be satisfied before coinsurance applies. Benefits listed with a copay are not subject to deductible unless noted.</i>						
<b>Maximum Lifetime Benefit</b> (per member)	Unlimited					
<b>Deductible</b> (per member or three times per family)	\$1,000	\$2,500	\$3,500	\$5,000	\$2,500	\$5,000
<b>Coinsurance</b> (Plan pays in-network)	WellPath pays 70% after Deductible			50% after Deductible		
<b>Coinsurance Maximum</b> (in-network after deductible, per benefit year, maximum two times the individual coinsurance maximum)	\$3,000					
<b>Physician Office Visit (PCP)</b> General Physician, Family Practitioner, Pediatrician or Internist; Includes Office Visits, Simple Labs and X-rays (when performed in office).	\$25 Copay			\$30 Copay		
<b>Specialty Physician Office Services</b> Includes Simple Labs and X-rays (when performed in office), Allergy Testing and Treatments	\$50 Copay			\$60 Copay		
<b>Preventive Services</b> Includes Pap Smears, Mammograms, PSA Testing, Colorectal Cancer Screening, Routine Child/Adult Well-Care Exams and immunizations.	WellPath pays 100%					
<b>Urgent Care Facility Services</b>	\$50 Copay			\$60 Copay		
<b>Emergency Room Services</b> (waived if admitted to the hospital)	\$250 Copay		WellPath pays 70% after Deductible	\$250 Copay	WellPath pays 50% after Deductible	
<b>Inpatient and Outpatient Hospital Services</b> Includes X-ray, Lab, Diagnostic Services, MRI, CT and PET scans, Other Nuclear Med, Surgery, Anesthesia, Chemotherapy, Radiation Treatment	WellPath pays 70% after Deductible			WellPath pays 50% after Deductible		
<b>Vision Exam</b> (every 12 months)	\$25 Copay for in-network routine vision exam			\$30 Copay		
<b>Chiropractic Services</b> (20 visits per benefit year)	\$25 Copay			\$30 Copay		
<b>Prescription Drug Coverage</b>	<i>Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90-day supply.</i>					
<b>Prescription Deductible</b> (applies to all Tiers)	\$200			\$500		
<b>Tier 1: Preferred Generic</b>	\$10					
<b>Tier 2: Formulary Brand</b>	\$35					
<b>Tier 3: Non-Formulary</b>	\$50					
<b>Tier 4: Self-Administered Injectable Drugs and some Specialty Medications</b>	10%					
Out-of-Network Benefits	Plan 9A	Plan 10A	Plan 11A	Plan 12A	Plan 14A	Plan 16A
<b>Deductible</b> (per member, maximum three times per family)	\$2,000	\$5,000	\$7,000	\$10,000	\$5,000	\$10,000
<b>Coinsurance</b>	WellPath pays 60% after Deductible			WellPath pays 40% after Deductible		
<b>Coinsurance Maximum</b> (per member, maximum two times in-network)	\$6,000					
<b>Physician Office Services, Urgent Care Facility Services, Inpatient and Outpatient Hospital Services</b>	WellPath pays 70% after Deductible			WellPath pays 40% after Deductible		

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## EXTRA VALUE COPAY PLANS – WELLPATH SELECT, INC.

In-Network Benefits	Plan 20A	Plan 21A	Plan 23A	Plan 25A	Plan 27A	Plan 29A	Plan 31A
<i>Benefit year deductible must be satisfied before coinsurance applies. Benefits listed with a copay are not subject to deductible unless noted.</i>							
<b>Maximum Lifetime Benefit</b> (per member)	Unlimited						
<b>Deductible</b> (per member or three times per family)	\$1,500	\$2,500	\$5,000	\$2,500	\$5,000	\$2,500	\$5,000
<b>Coinsurance</b> (Plan pays in-network)	WellPath pays 70% after Deductible						
<b>Coinsurance Maximum</b> (in-network after deductible, per benefit year, maximum two times the individual coinsurance maximum )	\$3,000						
<b>Physician Office Visit (PCP)</b> General Physician, Family Practitioner, Pediatrician or Internist; Includes Office Visits, Simple Labs and X-rays (when performed in office).	\$25 Copay		\$30 Copay		\$40 Copay		
<b>Specialty Physician Office Services</b> Includes Simple Labs and X-rays (when performed in office), Allergy Testing and Treatments	\$50 Copay		\$60 Copay		\$80 Copay		
<b>Preventive Services</b> Includes Pap Smears, Mammograms, PSA Testing, Colorectal Cancer Screening, Routine Child/Adult Well-Care Exams and immunizations.	WellPath pays 100%						
<b>Urgent Care Facility Services</b>	\$50 Copay		\$60 Copay		\$80 Copay		
<b>Emergency Room Services</b> (waived if admitted to the hospital)	\$500 Copay						
<b>Inpatient and Outpatient Hospital Services</b> Includes X-ray, Lab, Diagnostic Services, MRI, CT and PET scans, Other Nuclear Med, Surgery, Anesthesia, Chemotherapy, Radiation Treatment	WellPath pays 70% after Deductible						
<b>Vision Exam</b> (every 12 months)	\$25 Copay		\$30 Copay		\$40 Copay		
<b>Chiropractic Services</b> (20 visits per benefit year)	\$25 Copay		\$30 Copay		\$40 Copay		
<b>Prescription Drug Coverage A</b>	<i>Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90-day supply.</i>						
<b>Prescription Deductible</b>	\$200 applies to Tiers 2, 3, 4		\$500 applies to Tiers 2, 3, 4		\$1,000 applies to Tiers 2, 3, 4		
<b>Tier 1: Preferred Generic</b>	\$10						
<b>Tier 2: Formulary Brand</b>	\$35		\$50		\$70		
<b>Tier 3: Non-Formulary</b>	\$50		\$75		\$100		
<b>Tier 4: Self-Administered Injectable Drugs and some Specialty Medications</b>	10%						
Out-of-Network Benefits	Plan 20A	Plan 21A	Plan 23A	Plan 25A	Plan 27A	Plan 29A	Plan 31A
<b>Deductible</b> (per member, maximum three times per family)	\$3,000	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000
<b>Coinsurance</b>	WellPath pays 60% after Deductible						
<b>Coinsurance Maximum</b> (per member, maximum two times in-network)	\$6,000						
<b>Physician Office Services, Urgent Care Facility Services, Inpatient and Outpatient Hospital Services</b>	WellPath pays 60% after Deductible						

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## QHDHP PLANS – WELLPATH SELECT, INC.

In-Network Benefits	QHDHP 7A	QHDHP 10A	QHDHP 13A	QHDHP 16A	QHDHP 19A
<i>Benefit year deductible must be satisfied before coinsurance applies. Benefits listed with a copay are not subject to deductible unless noted.</i>					
<b>Maximum Lifetime Benefit</b> (per member)	Unlimited				
<b>Deductible</b> (per member)	\$2,000	\$2,700	\$3,000	\$4,000	\$5,000
<b>Family Deductible</b> (per family)	\$4,000	\$5,450	\$6,000	\$8,000	\$10,000
<b>Coinsurance</b> (Plan pays in-network)	WellPath pays 100% after Deductible				
<b>Maximum Out-of-Pocket</b> (in-network after deductible, per benefit year, maximum two per family)	\$2,000	\$2,700	\$3,000	\$4,000	\$5,000
<b>Physician Office Visit (PCP)</b> General Physician, Family Practitioner, Pediatrician or Internist; Includes Office Visits, Labs & X-rays (when performed in office).	WellPath pays 100% after Deductible				
<b>Specialty Physician Office Services</b> Includes Labs and X-rays (when performed in office), Allergy Testing and Treatments	WellPath pays 100% after Deductible				
<b>Preventive Services</b> Includes Pap Smears, Mammograms, PSA Testing, Colorectal Cancer Screening, Routine Child/Adult Well-Care Exams and immunizations.	WellPath pays 100%				
<b>Urgent Care Facility Services</b>	WellPath pays 100% after Deductible				
<b>Emergency Room Services</b> (waived if admitted to the hospital)	WellPath pays 100% after Deductible				
<b>Inpatient and Outpatient Hospital Services</b> Includes X-ray, Lab, Diagnostic Services, MRI, CT and PET scans, Other Nuclear Med, Surgery, Anesthesia, Chemotherapy, Radiation Treatment	WellPath pays 100% after Deductible				
<b>Prescription Drug Coverage</b>	<i>Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90-day supply.</i>				
<b>Prescription Deductible</b>	Not Applicable				
<b>Tier 1: Preferred Generic</b>	WellPath pays 100% after Deductible				
<b>Tier 2: Formulary Brand</b>	WellPath pays 100% after Deductible				
<b>Tier 3: Non-Formulary</b>	WellPath pays 100% after Deductible				
<b>Tier 4: Self-Administered Injectable Drugs and some Specialty Medications</b>	WellPath pays 100% after Deductible				
Out-of-Network Benefits	QHDHP 7A	QHDHP 10A	QHDHP 13A	QHDHP 16A	QHDHP 19A
<b>Deductible</b> (per member)	\$4,000	\$5,450	\$6,000	\$8,000	\$10,000
<b>Family Deductible</b> (per family)	\$8,000	\$10,900	\$12,000	\$16,000	\$20,000
<b>Coinsurance</b>	WellPath pays 70% after Deductible				
<b>Maximum Out-of-Pocket</b> (per member)	\$5,250	\$6,650	\$7,250	\$9,250	\$11,250
<b>Maximum Out-of-Pocket</b> (per family)	\$10,500	\$13,400	\$12,150	\$17,250	\$22,200
<b>Physician Office Services, Urgent Care Facility Services, Inpatient and Outpatient Hospital Services</b>	WellPath pays 70% after Deductible				

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