



OPEN ENROLLMENT PLAN COMPARISON

Enrollee Services:	Basic Indemnity Plan Coverage	PPO Standard Plan	
		Enrollee Copays & Coverage Preferred Provider	Enrollee Copays & Coverage Non-Preferred Provider
Individual - Calendar Year Deductible (Per insured)	\$1,000	\$750 (Only applies where noted)	\$750 (Only applies where noted)
Individual - Calendar Year Out-of-Pocket Maximum (Per insured - does not include deductible)	\$5,000	\$3,000	\$5,000
Coinsurance (What the plan pays after the deductible is met but before the out-of-pocket maximum is reached; after the out-of-pocket maximum is reached services are covered at 100% of Maximum Allowable Charge.)	50%	80%	60% of SummaCare's Maximum Allowable Charge
Restricted Annual Limits Per Calendar Year (Annual limit per member per calendar year for all Essential Benefits.)	\$750,000 for calendar year 2011 \$1,250,000 for calendar year 2012 \$2,000,000 for calendar year 2013	\$750,000 for Calendar Year 2011 \$1,250,000 for Calendar Year 2012 \$2,000,000 for Calendar Year 2013	
Lifetime Benefit Maximum	Unlimited	Unlimited	
Office Services:			
Primary Physician Visits	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Preventive Care (Includes mammograms, immunizations, well-child care and preventive services as defined by the United States Preventive Services Task Force under grades A and B preventive services. Refer to SummaCare's Health Care Reform Rider.)	100% for in-network contracted providers; 50% (Subject to deductible) for non-network providers	100%	60% (Subject to deductible)
Gynecological Visits	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Specialist Visits	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient Services: (May Require Prior Authorization)			
X-ray, Laboratory & Other Diagnostic Services	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient Surgery	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)

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Inpatient Hospital Services: (Requires Prior Authorization)			
Inpatient Care	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Rehabilitative Services		80% (Subject to deductible)	60% (Subject to deductible)
Maternity Services:	Not covered; limited to complications of pregnancy only at 50% (Subject to deductible)	\$3,000 per occurrence maximum	
Office Visits	n/a	80% for initial visit only (Subject to deductible)	60% (Subject to deductible)
Hospital Services (48 hours for vaginal delivery; 96 hours for Cesarean delivery) (If discharged early, home care is covered for up to 72 hours after discharge.)	n/a	80% (Subject to deductible)	60% (Subject to deductible)
Prenatal-Postpartum Care	n/a	80% (Subject to deductible)	60% (Subject to deductible)
Emergency/Urgent Care Services:			
Emergency Care (Any hospital emergency room visit inside or outside of the service area)	\$75 copay per visit; waived if admitted	80% after \$75 copay; Copay waived if admitted	80% after \$75 copay; Copay waived if admitted
Urgent Care (Urgently needed care that is not life-or limb-threatening)	50%	80% (Subject to deductible)	60% (Subject to deductible)
Mental Health and Substance Abuse Services:			
Biologically Based Mental Health:			
Inpatient	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Non-Biologically Based Mental Health and Substance Abuse Disorders:			
Inpatient (limited to 21 days per calendar year)	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient (limited to 20 visits per calendar year)	50% (Subject to deductible)	\$50 copay per visit (Subject to deductible)	\$50 copay per visit (Subject to deductible)
Other Services:			
Ambulance Services	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)

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Other Services: (continued)			
Chiropractic Services (limited to 10 visits per calendar year)	\$25 eligible charge per visit plan will pay or 50% (Subject to deductible) - the lesser of	\$25 eligible payment per visit plan will pay or 80% (Subject to deductible) the lesser of	\$25 eligible payment per visit plan will pay or 60% (Subject to deductible) the lesser of
Durable Medical Equipment (Purchase or rental not to exceed a six-month period, whichever is less)	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Home Health Care (limited to 30 days per calendar year)	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Hospice Services	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Rehabilitative Services (limited to 20 visits per calendar year for physical/occupational and speech therapy)	\$40 eligible charge per visit plan will pay or 50% (Subject to deductible) - the lesser of	\$40 eligible payment per visit plan will pay or 80% (Subject to deductible) the lesser of	\$40 eligible payment per visit plan will pay or 60% (Subject to deductible) the lesser of
Skilled Nursing Facility (limited to 100 days per calendar year)	50% (Subject to deductible)	80% (Subject to deductible)	60% (Subject to deductible)
Prescription Drugs:	\$2,500 maximum per person per calendar year (Pharmacy Rider NC)	\$2,500 maximum per person per calendar year (Pharmacy Rider NC)	