



**Orthodox HealthPlans Medical Benefits
PPO Benefit Highlights**

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
Deductible (per calendar year)	\$400 Individual \$800 Family	\$750 Individual \$1500 Family
Coinsurance Limit	\$3000 Individual \$6000 Family	\$4000 Individual \$8000 Family

PREVENTATIVE CARE	IN NETWORK	OUT OF NETWORK
Routine Physicals - adults 19 & Older 1 exam every 12 months	100% after \$25 copay	70% after deductible
Well Baby Care/Immunizations	100% no deductible or copay	70% after deductible
Routine Mammogram	90% no deductible or copay	70% after deductible
Routine OB/GYN Exam - 1 per year	100% after \$35 copay	70% after deductible

PHYSICIAN SERVICES	IN NETWORK	OUT OF NETWORK
Office Visits, non-surgical	100% after \$25 copay	70% after deductible
Allergy Test/Treat (by Physician)	100% after \$35 copay	70% after deductible
Allergy Injections (not by Physician)	90% after deductible	70% after deductible
Diagnostic X-ray & Lab	90% no deductible or copay	70% no deductible
Specialist Office Visits	100% after \$35 copay	70% after deductible
Surgical Services	90% after deductible	70% after deductible
Physician In-Hospital Services	90% after deductible	70% after deductible
Other Physician Services	90% after deductible	70% after deductible
Maternity Care	SAAOCE*	SAAOCE*

HOSPITAL SERVICES	IN NETWORK	OUT OF NETWORK
Inpatient Coverage	90% after \$250 per confinement and deductible	70% after \$250 per confinement and deductible
Outpatient Coverage	90% after deductible	70% after deductible
Emergency Room Visit	90% after \$150 copay waived if admitted	70% after \$50 copay waived if admitted
Non-emergency use of ER	50% after deductible	50% after deductible
Maternity Care	SAAOCE*	SAAOCE*

PRESCRIPTION DRUG BENEFIT	IN NETWORK	OUT OF NETWORK
Retail: 30 day supply		
Generic	\$15 copay	Not covered
Formulary	\$25 copay	Not covered
Non-formulary	\$40 copay	Not covered
Mail order: 90 day supply		
Generic	\$30 copay	Not covered
Formulary	\$50 copay	Not covered
Non-formulary	\$80 copay	Not covered



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MENTAL HEALTH	IN NETWORK	OUT OF NETWORK
Inpatient- up to 30 days per calendar year	90% after \$250 per confinement fee and deductible	70% after \$250 confinement fee and deductible
Outpatient- up to 30 visits per calendar year	90% after deductible	70% after deductible
Crisis Intervention - 3 visits per calendar year	90% after deductible	70% after deductible
SUBSTANCE ABUSE	IN NETWORK	OUT OF NETWORK
Inpatient - up to 30 days per calendar year	90% after \$250 confinement fee and deductible	70% after \$250 confinement fee and deductible
Outpatient- up to 60 visits per calendar year	90% after deductible	70% after deductible
OTHER BENEFITS	IN NETWORK	OUT OF NETWORK
Skilled Nursing Facility (other than at physician's office)	90% after deductible up to 90 days per yr. 90% no deductible or copay	70% after deductible 70% - deductible waived
Hospice care	Same as skilled nursing	Same as skilled nursing
Inpatient Coverage	80% after deductible up to 30 days per year	Same as In Network
Outpatient Coverage	80% after deductible. Max of \$5000	Same as In Network
Ambulance	80% after deductible	Same as In Network
Durable Medical Equipment	80% after deductible	Same as In Network
Short Term Rehabilitation	80% after deductible	Same as In Network

*Same As Any Other Covered Expense

NOTE:

This is a Summary of Plan Benefits Only. The Master Policy Contract holds more detailed information on coverage. In the event of discrepancies, the Master Contract shall be binding, subject to State Mandates.