80/20 Plans

	80/20 1500	80/20 2500	80/20 3500	80/20 5500
DEDUCTIBLE	$1,500 Single / $3,000 Family	$2,500 Single / $5,000 Family	$3,500 Single / $7,000 Family	$5,500 Single / $11,000 Family
CO-INSURANCE	20% Member / 80% Plan	20% Member / 80% Plan	20% Member / 80% Plan	20% Member / 80% Plan
CO-INSURANCE MAXIMUM	$2,500 Single / $5,000 Family	$2,500 Single / $5,000 Family	$2,500 Single / $5,000 Family	$2,500 Single / $5,000 Family
OUT-OF-POCKET LIMIT (Deductible + Co-Insurance Max) (OOP Limit does not include copays and Rx copays)	$4,000 Single / $8,000 Family	$5,000 Single / $10,000 Family	$6,000 Single / $12,000 Family	$8,000 Single / $16,000 Family
ACA MAXIMUM OUT-OF-POCKET	$8,550 Single / $17,100 Family	$8,550 Single / $17,100 Family	$8,550 Single / $17,100 Family	$8,550 Single / $17,100 Family
PREVENTIVE SERVICES	100% Coverage			
PHYSICIAN SERVICES				
- Primary Care Office Visit	Tier 1 Preferred Providers: $10 Copay (Tier 2 In-Network Providers: $50 Copay), then 100% to $250 per visit, then Deductible / Co-insurance			
- Specialist Office Visit	Tier 1 Preferred Providers: $30 Copay (Tier 2 In-Network Providers: $60 Copay), then 100% to $250 per visit, then Deductible / Co-insurance			
- Urgent Care Office Visit	$50 Copay, then 100% to $500 per visit, then Deductible / Co-insurance			
TELEPHONIC PHYSICIAN CONSULTATIONS	$0 Copay			
OUTPATIENT LAB	100% Coverage if preferred vendor, otherwise Deductible / Co-insurance			
OUTPATIENT RADIOLOGY AND IMAGING	*Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging*			
- Physician Office / Freestanding Imaging Ctr.	Tier 1 Preferred Providers: Deductible / Co-insurance (Tier 2 In-Network Providers: $200 Copay, then Deductible / Co-insurance)			
- Hospital Outpatient	$500 Copay, then Deductible / Co-insurance			
DIABETIC SUPPLIES	100% Coverage if preferred vendor, otherwise 50% cost to member through Rx Benefit			
ALLERGY TREATMENT	$25 Copay, then 100% to $100 per visit			
OUTPATIENT REHAB & THERAPY	Deductible / Co-insurance			
CHIROPRACTIC SERVICES	Deductible / Co-insurance			
EMERGENCY SERVICES				
- Hospital ER (Facility Charge Only)	$250 Copay, then Deductible / Co-insurance *(Copay waived if admitted)*			
- ER Professional Service	$50 Copay, then 100% to $500 per visit, then Deductible / Co-insurance			
- Ambulance	Deductible / Co-insurance			
- Air Ambulance	$2,500 Copay, then Deductible / Co-insurance			
OUTPATIENT SURGICAL PROCEDURES	*Pre-certification required prior to scheduling*			
- Physician Office / Freestanding Surgery Ctr.	Tier 1 Preferred Providers: $250 Copay, then 100% to $5,000, then Deductible / Co-insurance (Tier 2 In-Network Providers: $300 Copay, then Deductible / Co-insurance)			
- Physician & Surgeon Professional Services	Tier 1 Preferred Providers: Deductible / Co-insurance (Tier 2 In-Network Providers: $200 Copay, then Deductible / Co-insurance)			
- Anesthesia Services (Physician / CRNA)	Deductible / Co-insurance			
- Hospital Outpatient	$1,000 Copay per visit, then Deductible / Co-insurance			
INPATIENT HOSPITALIZATION	*All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins*			
- Medical Facility Services	$500 Copay per confinement, then Deductible / Co-insurance			
- Physician & Surgeon Professional Services	Tier 1 Preferred Providers: Deductible / Co-insurance (Tier 2 In-Network Providers: $200 Copay, then Deductible / Co-insurance)			
- Anesthesia Services (Physician / CRNA)	Deductible / Co-insurance			
HOME HEALTH, SKILLED NURSING & HOSPICE CARE	Deductible / Co-insurance			
MENTAL HEALTH & SUBSTANCE ABUSE	Coverage provided as required by the Mental Health Parity Law			
DURABLE MEDICAL EQUIPMENT	Deductible / Co-insurance			
PRESCRIPTION DRUG BENEFITS	*Refer to Preferred Formulary and Summary Plan Document (SPD) for additional details*			
- Generic	$1 Copay / $15 Copay			
- Brand / Non-Preferred Brand / Specialty	$50 Copay / $80 Copay / 20% to $1,000 per Rx			
- International Mail Order - Brand	$0 Copay if preferred vendor (voluntary participation)			

ProviDRs Care with NexUS

NOTE: This outline is intended as a brief overview of the actual plan and represents In-network benefit levels. The In-network Out-of-Pocket Maximum (including deductible, co-insurance, copays and Rx copays) for each plan is $7,900 Single / $15,800 Family. Out-of-network deductibles are 2x In-network Deductible. Out-of-network Co-Insurance percentage and out-of-pocket amounts vary by plan selection. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from NexUs Health Plans or your sales representative. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.

50/50 Plans

	50/50 1500	50/50 2500	50/50 3500	50/50 5500
DEDUCTIBLE	$1,500 Single / $3,000 Family	$2,500 Single / $5,000 Family	$3,500 Single / $7,000 Family	$5,500 Single / $11,000 Family
CO-INSURANCE	50% Member / 50% Plan	50% Member / 50% Plan	50% Member / 50% Plan	50% Member / 50% Plan
CO-INSURANCE MAXIMUM	$2,500 Single / $5,000 Family	$2,500 Single / $5,000 Family	$2,500 Single / $5,000 Family	$2,500 Single / $5,000 Family
OUT-OF-POCKET LIMIT (Deductible + Co-Insurance Max) (OOP Limit does not include copays and Rx copays)	$4,000 Single / $8,000 Family	$5,000 Single / $10,000 Family	$6,000 Single / $12,000 Family	$8,000 Single / $16,000 Family
ACA MAXIMUM OUT-OF-POCKET	$8,550 Single / $17,100 Family	$8,550 Single / $17,100 Family	$8,550 Single / $17,100 Family	$8,550 Single / $17,100 Family
PREVENTIVE SERVICES	100% Coverage			
PHYSICIAN SERVICES				
- Primary Care Office Visit	Tier 1 Preferred Providers: $10 Copay (Tier 2 In-Network Providers: $50 Copay), then 100% to $250 per visit, then Deductible / Co-insurance			
- Specialist Office Visit	Tier 1 Preferred Providers: $30 Copay (Tier 2 In-Network Providers: $60 Copay), then 100% to $250 per visit, then Deductible / Co-insurance			
- Urgent Care Office Visit	$50 Copay, then 100% to $500 per visit, then Deductible / Co-insurance			
TELEPHONIC PHYSICIAN CONSULTATIONS	$0 Copay			
OUTPATIENT LAB	100% Coverage if preferred vendor, otherwise Deductible / Co-insurance			
OUTPATIENT RADIOLOGY AND IMAGING	*Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging*			
- Physician Office / Freestanding Imaging Ctr.	Tier 1 Preferred Providers: Deductible / Co-insurance (Tier 2 In-Network Providers: $200 Copay, then Deductible / Co-insurance)			
- Hospital Outpatient	$500 Copay, then Deductible / Co-insurance			
DIABETIC SUPPLIES	100% Coverage if preferred vendor, otherwise 50% cost to member through Rx Benefit			
ALLERGY TREATMENT	$25 Copay, then 100% to $100 per visit			
OUTPATIENT REHAB & THERAPY	Deductible / Co-insurance			
CHIROPRACTIC SERVICES	Deductible / Co-insurance			
EMERGENCY SERVICES				
- Hospital ER (Facility Charge Only)	$250 Copay, then Deductible / Co-insurance *(Copay waived if admitted)*			
- ER Professional Service	$50 Copay, then 100% to $500 per visit, then Deductible / Co-insurance			
- Ambulance	Deductible / Co-insurance			
- Air Ambulance	$2,500 Copay, then Deductible / Co-insurance			
OUTPATIENT SURGICAL PROCEDURES	*Pre-certification required prior to scheduling*			
- Physician Office / Freestanding Surgery Ctr.	Tier 1 Preferred Providers: $250 Copay, then 100% to $5,000, then Deductible / Co-insurance (Tier 2 In-Network Providers: $300 Copay, then Deductible / Co-insurance)			
- Physician & Surgeon Professional Services	Tier 1 Preferred Providers: Deductible / Co-insurance (Tier 2 In-Network Providers: $200 Copay, then Deductible / Co-insurance)			
- Anesthesia Services (Physician / CRNA)	Deductible / Co-insurance			
- Hospital Outpatient	$1,000 Copay per visit, then Deductible / Co-insurance			
INPATIENT HOSPITALIZATION	*All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins*			
- Medical Facility Services	$500 Copay per confinement, then Deductible / Co-insurance			
- Physician & Surgeon Professional Services	Tier 1 Preferred Providers: Deductible / Co-insurance (Tier 2 In-Network Providers: $200 Copay, then Deductible / Co-insurance)			
- Anesthesia Services (Physician / CRNA)	Deductible / Co-insurance			
HOME HEALTH, SKILLED NURSING & HOSPICE CARE	Deductible / Co-insurance			
MENTAL HEALTH & SUBSTANCE ABUSE	Coverage provided as required by the Mental Health Parity Law			
DURABLE MEDICAL EQUIPMENT	Deductible / Co-insurance			
PRESCRIPTION DRUG BENEFITS	*Refer to Preferred Formulary and Summary Plan Document (SPD) for additional details*			
- Generic	$1 Copay / $15 Copay			
- Brand / Non-Preferred Brand / Specialty	$50 Copay / $80 Copay / 20% to $1,000 per Rx			
- International Mail Order - Brand	$0 Copay if preferred vendor (voluntary participation)			

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NOTE: This outline is intended as a brief overview of the actual plan and represents In-network benefit levels. The In-network Out-of-Pocket Maximum (including deductible, co-insurance, copays and Rx copays) for each plan is $7,900 Single / $15,800 Family. Out-of-network deductibles are 2x In-network Deductible. Out-of-network Co-Insurance percentage and out-of-pocket amounts vary by plan selection. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from NexUs Health Plans or your sales representative. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.

QualifiedHDHP	QualifiedHDHP 3000	QualifiedHDHP 6500
DEDUCTIBLE	$3,000 Single / $6,000 Family (Embedded Deductible)	$6,500 Single / $13,000 Family (Embedded Deductible)
CO-INSURANCE	None	None
CO-INSURANCE MAXIMUM	No Co-insurance Responsibility	No Co-insurance Responsibility
OUT-OF-POCKET LIMIT (Deductible + Co-Insurance Max) (OOP Limit does not include copays and Rx copays)	$3,000 Single / $6,000 Family	$6,500 Single / $13,000 Family
ACA MAXIMUM OUT-OF-POCKET	$8,550 Single / $17,100 Family	$8,550 Single / $17,100 Family
PREVENTIVE SERVICES	100% Coverage	
PHYSICIAN SERVICES		
- Primary Care Office Visit	Tier 1 Preferred Providers: After Deductible, $10 Copay (Tier 2 In-Network Providers: After Deductible, $50 Copay)	
- Specialist Office Visit	Tier 1 Preferred Providers: After Deductible, $30 Copay (Tier 2 In-Network Providers: After Deductible, $60 Copay)	
- Urgent Care Office Visit	Deductible	
TELEPHONIC PHYSICIAN CONSULTATIONS	$20 Copay (Copay waived during the declared Public Health Emergency Period)	
OUTPATIENT LAB	Deductible	
OUTPATIENT RADIOLOGY AND IMAGING	*Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging*	
- Physician Office / Freestanding Imaging Ctr.	Tier 1 Preferred Providers: Deductible (Tier 2 In-Network Providers: After Deductible, $200 Copay)	
- Hospital Outpatient	After Deductible, $500 Copay	
DIABETIC SUPPLIES	Deductible	
ALLERGY TREATMENT	Deductible	
OUTPATIENT REHAB & THERAPY	Deductible	
CHIROPRACTIC SERVICES	Deductible	
EMERGENCY SERVICES		
- Hospital ER (Facility Charge Only)	After Deductible, $250 Copay *(Copay waived if admitted)*	
- ER Professional Service	Deductible	
- Ambulance	Deductible	
- Air Ambulance	Deductible	
OUTPATIENT SURGICAL PROCEDURES	*Pre-certification required prior to scheduling*	
- Physician Office / Freestanding Surgery Ctr.	Tier 1 Preferred Providers: Deductible (Tier 2 In-Network Providers: After Deductible, $300 Copay)	
- Physician & Surgeon Professional Services	Tier 1 Preferred Providers: Deductible (Tier 2 In-Network Providers: After Deductible, $200 Copay)	
- Anesthesia Services (Physician / CRNA)	Deductible	
- Hospital Outpatient	After Deductible, $1,000 Copay per visit	
INPATIENT HOSPITALIZATION	*All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins*	
- Medical Facility Services	Deductible	
- Physician & Surgeon Professional Services	Tier 1 Preferred Providers: Deductible (Tier 2 In-Network Providers: After Deductible, $200 Copay)	
- Anesthesia Services (Physician / CRNA)	Deductible	
HOME HEALTH, SKILLED NURSING & HOSPICE CARE	Deductible	
MENTAL HEALTH & SUBSTANCE ABUSE	Coverage provided as required by the Mental Health Parity Law	
DURABLE MEDICAL EQUIPMENT	Deductible	
PRESCRIPTION DRUG BENEFITS	*Refer to Preferred Formulary and Summary Plan Document (SPD) for additional details*	
- Generic	After Deductible, $1 Copay / $15 Copay	
- Brand / Non-Preferred Brand / Specialty	After Deductible, $50 Copay / $80 Copay / 20% to $1,000 per Rx	
- International Mail Order - Brand	After Deductible, $0 Copay if preferred vendor (voluntary participation)	

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NOTE: This outline is intended as a brief overview of the actual plan and represents In-network benefit levels. The In-network Out-of-Pocket Maximum (including deductible, co-insurance, copays and Rx copays) for each plan is $6,750 Single / $13,500 Family. Out-of-network deductibles are 2x In-network Deductible. Out-of-network Co-Insurance percentage and out-of-pocket amounts vary by plan selection. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from NexUs Health Plans or your sales representative. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.