| HealthyChoice | HealthyChoice 1000 | HealthyChoice 1500 | HealthyChoice 2000 | HealthyChoice 2500 |
|---|---|---|---|---|
| **DEDUCTIBLE** | $1,000 Single / $2,000 Family | $1,500 Single / $3,000 Family | $2,000 Single / $4,000 Family | $2,500 Single / $5,000 Family |
| **LIFESTYLE DEDUCTIBLE** (Reduced Deductible based on wellness points earned) | $500 Single / $1,000 Family | $500 Single / $1,000 Family | $500 Single / $1,000 Family | $500 Single / $1,000 Family |
| **CO-INSURANCE** | 80/20 | 80/20 | 80/20 | 80/20 |
| **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) | $3,500 Single / $7,000 Family | $4,000 Single / $8,000 Family | $4,500 Single / $9,000 Family | $5,000 Single / $10,000 Family |
| **ACA MAXIMUM OUT-OF-POCKET** | $7,350 Single / $14,700 Family | $7,350 Single / $14,700 Family | $7,350 Single / $14,700 Family | $7,350 Single / $14,700 Family |
| **PREVENTIVE SERVICES** | 100% Coverage | | | |
| **PHYSICIAN SERVICES** | Office visit benefit includes all services provided during visit except lab services | | | |
| - Primary Care Office Visit | $30 Copay, then 100% to $250 per visit, then Deductible / Co-insurance | | | |
| - Specialist Office Visit | $50 Copay, then 100% to $250 per visit, then Deductible / Co-insurance | | | |
| - Physician & Surgeon Professional Services | Deductible / Co-insurance | | | |
| - Anesthesia Services (Physician / CRNA) | 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. | 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) | | | |
| - Urgent Care / ER Professional Services | $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. | Deductible / Co-insurance | | | |
| - Hospital Outpatient | $1,000 Copay per visit, then Deductible / Co-insurance | | | |
| - Implant Device | Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater) | | | |
| **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 | | | |
| - Anesthesiologist & Surgeon Fees | Deductible / Co-insurance | | | |
| **INPATIENT SURGICAL PROCEDURES** | Deductible / Co-insurance | | | |
| - Implant Device | Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater) | | | |
| **HOME HEALTH, SKILLED NURSING & HOSPICE CARE** | Deductible / Co-insurance | | | |
| **MENTAL HEALTH & SUBSTANCE ABUSE** | Deductible / Co-insurance | | | |
| **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 / 50% | | | |
| - International Mail Order - Brand | $0 Copay if preferred vendor (voluntary participation) | | | |

Lifestyle HEALTH PLANS *A World of Wellness*

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 $7,350 Single / $14,700 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 Lifestyle 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.

# Healthy100

| | Healthy100 2500 | Healthy100 3000 | Healthy100 3500 | Healthy100 5000 |
|---|---|---|---|---|
| **DEDUCTIBLE** | $2,500 Single / $5,000 Family | $3,000 Single / $6,000 Family | $3,500 Single / $7,000 Family | $5,000 Single / $10,000 Family |
| **LIFESTYLE DEDUCTIBLE** (Reduced Deductible based on wellness points earned) | $500 Single / $1,000 Family | $500 Single / $1,000 Family | $500 Single / $1,000 Family | $500 Single / $1,000 Family |
| **CO-INSURANCE** | None | None | None | None |
| **CO-INSURANCE MAXIMUM** | No Co-insurance Responsibility | No Co-insurance Responsibility | 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) | $2,500 Single / $5,000 Family | $3,000 Single / $6,000 Family | $3,500 Single / $7,000 Family | $5,000 Single / $10,000 Family |
| **ACA MAXIMUM OUT-OF-POCKET** | $7,350 Single / $14,700 Family | $7,350 Single / $14,700 Family | $7,350 Single / $14,700 Family | $7,350 Single / $14,700 Family |
| **PREVENTIVE SERVICES** | 100% Coverage | | | |
| **PHYSICIAN SERVICES** | Office visit benefit includes all services provided during visit except lab services | | | |
| - Primary Care Office Visit | $30 Copay, then 100% to $250 per visit, then Deductible / Co-insurance | | | |
| - Specialist Office Visit | $50 Copay, then 100% to $250 per visit, then Deductible / Co-insurance | | | |
| - Physician & Surgeon Professional Services | Deductible / Co-insurance | | | |
| - Anesthesia Services (Physician / CRNA) | 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. | 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) | | | |
| - Urgent Care / ER Professional Services | $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. | Deductible / Co-insurance | | | |
| - Hospital Outpatient | $1,000 Copay per visit, then Deductible / Co-insurance | | | |
| - Implant Device | Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater) | | | |
| **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 | | | |
| - Anesthesiologist & Surgeon Fees | Deductible / Co-insurance | | | |
| **INPATIENT SURGICAL PROCEDURES** | Deductible / Co-insurance | | | |
| - Implant Device | Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater) | | | |
| **HOME HEALTH, SKILLED NURSING & HOSPICE CARE** | Deductible / Co-insurance | | | |
| **MENTAL HEALTH & SUBSTANCE ABUSE** | Deductible / Co-insurance | | | |
| **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 / 50% | | | |
| - International Mail Order - Brand | $0 Copay if preferred vendor (voluntary participation) | | | |

Lifestyle HEALTH PLANS *A World of Wellness*

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 $7,350 Single / $14,700 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 Lifestyle 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.

| HealthyValue | HealthyValue 2500 | HealthyValue 3500 | HealthyValue 6850 | HealthyValue 10,000 |
|---|---|---|---|---|
| **DEDUCTIBLE** | $2,500 Single / $5,000 Family | $3,500 Single / $7,000 Family | $6,850 Single / $13,700 Family | $10,000 Single / $20,000 Family |
| **LIFESTYLE DEDUCTIBLE** (Reduced Deductible based on wellness points earned) | $500 Single / $1,000 Family | $500 Single / $1,000 Family | $500 Single / $1,000 Family | $500 Single / $1,000 Family |
| **CO-INSURANCE** | 50/50 | 50/50 | None | None |
| **CO-INSURANCE MAXIMUM** | $3,000 Single / $6,000 Family | $2,500 Single / $5,000 Family | 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) | $5,500 Single / $11,000 Family | $6,000 Single / $12,000 Family | $6,850 Single / $13,700 Family | $10,000 Single / $20,000 Family |
| **ACA MAXIMUM OUT-OF-POCKET** | $7,350 Single / $14,700 Family | $7,350 Single / $14,700 Family | $7,350 Single / $14,700 Family | ACA Compliant only with HRA Integration |
| **PREVENTIVE SERVICES** | 100% Coverage | | | |
| **PHYSICIAN SERVICES** | Office visit benefit includes all services provided during visit except lab services | | | |
| - Primary Care Office Visit | $30 Copay, then 100% to $250 per visit, then Deductible / Co-insurance | | | |
| - Specialist Office Visit | $50 Copay, then 100% to $250 per visit, then Deductible / Co-insurance | | | |
| - Physician & Surgeon Professional Services | Deductible / Co-insurance | | | |
| - Anesthesia Services (Physician / CRNA) | 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. | 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) | | | |
| - Urgent Care / ER Professional Services | $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. | Deductible / Co-insurance | | | |
| - Hospital Outpatient | $1,000 Copay per visit, then Deductible / Co-insurance | | | |
| - Implant Device | Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater) | | | |
| **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 | | | |
| - Anesthesiologist & Surgeon Fees | Deductible / Co-insurance | | | |
| **INPATIENT SURGICAL PROCEDURES** | Deductible / Co-insurance | | | |
| - Implant Device | Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater) | | | |
| **HOME HEALTH, SKILLED NURSING & HOSPICE CARE** | Deductible / Co-insurance | | | |
| **MENTAL HEALTH & SUBSTANCE ABUSE** | Deductible / Co-insurance | | | |
| **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 / 50% | | | |
| - International Mail Order - Brand | $0 Copay if preferred vendor (voluntary participation) | | | |

Lifestyle HEALTH PLANS *A World of Wellness*

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 $7,350 Single / $14,700 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 Lifestyle 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.

# HealthyConsumer

| | HealthyConsumer 3000 | HealthyConsumer 3500 | HealthyConsumer 5000 | HealthyConsumer 6500 |
|---|---|---|---|---|
| **DEDUCTIBLE** | $3,000 Single / $6,000 Family (Embedded Deductible) | $3,500 Single / $7,000 Family (Embedded Deductible) | $5,000 Single / $10,000 Family (Embedded Deductible) | $6,500 Single / $13,000 Family (Embedded Deductible) |
| **LIFESTYLE DEDUCTIBLE** (Reduced Deductible based on wellness points earned) | $500 Single / $1,000 Family | $500 Single / $1,000 Family | $500 Single / $1,000 Family | $500 Single / $1,000 Family |
| **CO-INSURANCE** | None | None | None | None |
| **CO-INSURANCE MAXIMUM** | No Co-insurance Responsibility | No Co-insurance Responsibility | 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 | $3,500 Single / $7,000 Family | $5,000 Single / $10,000 Family | $6,500 Single / $13,000 Family |
| **ACA MAXIMUM OUT-OF-POCKET** | $6,650 Single / $13,300 Family | $6,650 Single / $13,300 Family | $6,650 Single / $13,300 Family | $6,650 Single / $13,300 Family |
| **PREVENTIVE SERVICES** | 100% Coverage | | | |
| **PHYSICIAN SERVICES** | | | | |
| - Primary Care Office Visit | After Deductible, $30 Copay | | | |
| - Specialist Office Visit | After Deductible, $50 Copay | | | |
| - Physician & Surgeon Professional Services | Deductible / Co-insurance | | | |
| - Anesthesia Services (Physician / CRNA) | Deductible / Co-insurance | | | |
| **TELEPHONIC PHYSICIAN CONSULTATIONS** | $0 Copay | | | |
| **OUTPATIENT LAB** | Deductible / Co-insurance | | | |
| **OUTPATIENT RADIOLOGY AND IMAGING** | | | | |
| - Physician Office / Freestanding Imaging Ctr. | Deductible / Co-insurance | | | |
| - Hospital Outpatient | Deductible / Co-insurance | | | |
| **DIABETIC SUPPLIES** | Deductible / Co-insurance | | | |
| **ALLERGY TREATMENT** | Deductible / Co-insurance | | | |
| **OUTPATIENT REHAB & THERAPY** | Deductible / Co-insurance | | | |
| **CHIROPRACTIC SERVICES** | Deductible / Co-insurance | | | |
| **EMERGENCY SERVICES** | | | | |
| - Hospital ER (Facility Charge Only) | Deductible / Co-insurance | | | |
| - Urgent Care / ER Professional Services | Deductible / Co-insurance | | | |
| - Ambulance | Deductible / Co-insurance | | | |
| - Air Ambulance | Deductible / Co-insurance | | | |
| **OUTPATIENT SURGICAL PROCEDURES** | | | | |
| - Physician Office / Freestanding Surgery Ctr. | Deductible / Co-insurance | | | |
| - Hospital Outpatient | Deductible / Co-insurance | | | |
| - Implant Device | Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater) | | | |
| **INPATIENT HOSPITALIZATION** | | | | |
| - Medical Facility Services | Deductible / Co-insurance | | | |
| - Anesthesiologist & Surgeon Fees | Deductible / Co-insurance | | | |
| **INPATIENT SURGICAL PROCEDURES** | Deductible / Co-insurance | | | |
| - Implant Device | Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater) | | | |
| **HOME HEALTH, SKILLED NURSING & HOSPICE CARE** | Deductible / Co-insurance | | | |
| **MENTAL HEALTH & SUBSTANCE ABUSE** | Deductible / Co-insurance | | | |
| **DURABLE MEDICAL EQUIPMENT** | Deductible / Co-insurance | | | |
| **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 / 50% | | | |
| - International Mail Order - Brand | After Deductible, $0 Copay if preferred vendor (voluntary participation) | | | |

Lifestyle HEALTH PLANS *A World of Wellness*

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 $6,650 Single / $13,300 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 Lifestyle 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.