# New Horizon Plans
# In-Network Benefits Plan Comparison

wellaway.com

WellAway

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| Cost Share Features | 3000 | 5000 | 7000 |
|---|---|---|---|
| **Policy Year Deductibles - Embedded** | | | |
| Individual Deductible (The amount you pay) | $3,000 | $5,000 | $7,000 |
| Family Deductible (The amount your family pays) | $6,000 | $10,000 | $14,000 |
| **Coinsurance** (This Summary of Benefits states the percentage of the Allowed Amount **your plan pays** for Covered Services) | 80% | 70% | 60% |
| **Out-of-Pocket Maximums - Embedded** | | | |
| Individual Out-of-Pocket Maximum | $5,500 | $7,000 | $9,000 |
| Family Out-of-Pocket Maximum | $11,000 | $14,000 | $18,000 |

## MEDICAL HEALTH BENEFITS

### Preventive Services

| | |
|---|---|
| **Adult Wellness Services** (at all locations) | No Charge |
| **Child Wellness Services** (at all locations) | No Charge |
| **Mammograms** | No Charge |
| **Routine Colonoscopies** Ages 45+ (every 10 years) | No Charge |

### Office Services

| | | | |
|---|---|---|---|
| **Office Visits rendered by** Primary Care Physicians | $100 Copayment | $100 Copayment | $100 Copayment |
| Specialist Physicians and other health care professionals licensed to perform such Services | $150 Copayment | $150 Copayment | $150 Copayment |
| **Allergy Injections rendered by** Primary Care Physicians | $100 Copayment | $100 Copayment | $100 Copayment |
| Specialist Physicians and other health care professionals licensed to perform such Services | $150 Copayment | $150 Copayment | $150 Copayment |

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|---|---|---|---|
| **Advanced Imaging Services** (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) | $250 Copayment | $250 Copayment | $250 Copayment |
| Specialist Physicians and other health care professionals licensed to perform such Services | $250 Copayment | $250 Copayment | $250 Copayment |
| **Outpatient Physical Therapy and Spinal Manipulation** Primary Care Physicians | $100 Copayment | $100 Copayment | $100 Copayment |
| Specialist Physicians and other health care professionals licensed to perform such Services | $150 Copayment | $150 Copayment | $150 Copayment |
| **Virtual Health** | | | |
| **Virtual Visits** General Medicine | Your plan pays 100% | | |
| **Medical Pharmacy** | | | |
| **Prescription Drugs** administered in a Physician's office Generic Medications only | $30 Copayment per Drug, per visit | | |
| **Outpatient Diagnostic Services** | | | |
| **Independent Clinical Lab** *(Preferred Lab Quest Diagnostics)* | $100 Copayment | $100 Copayment | $100 Copayment |
| **Independent Diagnostic Testing Center** Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) | $250 Copayment | $250 Copayment | $250 Copayment |
| All other diagnostic Services (e.g., X-rays) | $200 Copayment | $200 Copayment | $200 Copayment |
| **Outpatient Hospital Facility** Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) | $500 Copayment | $500 Copayment | $500 Copayment |
| All other diagnostic Services (e.g., X-rays) | $300 Copayment | $300 Copayment | $300 Copayment |

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| Emergency and Urgent Care Services | 3000 | 5000 | 7000 |
|---|---|---|---|
| **Ambulance Services** | Your plan pays 80% Coinsurance | Your plan pays 70% Coinsurance | Your plan pays 60% Coinsurance |
| **Urgent Care** | $60 Copayment | $60 Copayment | $60 Copayment |
| **Emergency Room Visits**<br>Facility | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| Physician Services | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Hospital and Surgical Services** | | | |
| **Ambulatory Surgical Center**<br>Facility | $400 Copayment | $400 Copayment | $400 Copayment |
| Physician Services | Your plan pays 80% Coinsurance | Your plan pays 70% Coinsurance | Your plan pays 60% Coinsurance |
| **Inpatient Hospital**<br>Facility | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| Physician Services | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Outpatient Hospital**<br>Facility | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| Physician Services | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Behavioral Health Services** | | | |
| **Inpatient Hospital, Psychiatric or Substance Abuse Facility Services** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Outpatient Hospital, Psychiatric or Substance Abuse Facility** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Outpatient Physician and other health care professionals licensed to perform such Services rendered at**<br>Primary Care Physician Office | $100 Copayment | $100 Copayment | $100 Copayment |
| Specialist Office | $150 Copayment | $150 Copayment | $150 Copayment |
| Primary Care Physician at all other locations | $100 Copayment | $100 Copayment | $100 Copayment |
| Specialist at all other locations | $150 Copayment | $150 Copayment | $150 Copayment |

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| Maternity Care | 3000 | 5000 | 7000 |
|---|---|---|---|
| **Prenatal and postnatal physician consultations** | $150 Copayment (initial visit only) | $150 Copayment (initial visit only) | $150 Copayment (initial visit only) |
| **Labor and delivery** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Complications of Pregnancy** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Birthing center** | $400 Copayment | $400 Copayment | $400 Copayment |
| **Newborn care** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Infertility treatment** | Not covered | Not covered | Not covered |
| **Sterilization** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Other Services** | | | |
| **Dialysis Center** | $400 Copayment | $400 Copayment | $400 Copayment |
| **Durable Medical Equipment** (motorized wheelchair – medical necessity must be established and 50% Coinsurance will apply) | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Enteral Formula** | $60 Copayment | $60 Copayment | $60 Copayment |
| **Home Health Care** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Outpatient Habilitative / Rehabilitative** | $100 Copayment | $100 Copayment | $100 Copayment |
| **Prosthetic and Orthotic Devices** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Skilled Nursing Facility** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Hospice** | Deductible then your plan pays 80% Coinsurance | Deductible then your plan pays 70% Coinsurance | Deductible then your plan pays 60% Coinsurance |
| **Evacuation & Repatriation** | | | |
| **Medical Evacuation** | Paid in full up to $75,000 limit per covered person, per benefit period | | |
| **Repatriation of Mortal Remains** | Paid in full up to $25,000 lifetime limit per covered person | | |

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| Pediatric Dental Services | 3000 | 5000 | 7000 |
|---|---|---|---|
| **Preventive Dental Services**<br>• Oral Exam - *Once every 6 months in a Benefit Period*<br>• Cleaning and fluoride treatments - *Once every 6 months in a Benefit Period*<br>• Sealants – *Once per unrestored permanent molar every 36 months*<br>• Space maintainers to replace prematurely lost teeth.<br>• X-ray (bitewing – two films) – *Once every six months in a Benefit Period* | Your Plan pays 100% of UCR | Your Plan pays 100% of UCR | Your Plan pays 100% of UCR |
| **Basic Dental Services**<br>• Anesthesia – general anesthesia and intravenous sedation is covered only when rendered in connection with a covered surgical procedure.<br>• Endodontics – minor (such as pulpal therapy)<br>• Extractions (removal of teeth-except extractions for orthodontics)<br>• Palliative care (treatment to relieve pain or to keep an Accidental Dental Injury or dental Condition, such as an abscess from getting worse).<br>• Periodontics – minor (such as deep cleaning)<br>• Prosthodontics – minor (such as repair and relining of bridges, crowns and dentures)<br>• Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold) | Deductible then your plan pays 80% Coinsurance of UCR | Deductible then your plan pays 70% Coinsurance of UCR | Deductible then your plan pays 60% Coinsurance of UCR |
| **Major Dental Services**<br>• Endodontics – major (such as root canal treatment)<br>• Periodontics – surgical (such as gingivectomy)<br>• Prosthodontics – major (such as crowns and dentures - *limited to once every 60 months*).<br>• Implants and orthodontia Services may be covered, when Medically Necessary, and with prior coverage authorization. | Deductible then your plan pays 80% Coinsurance of UCR | Deductible then your plan pays 70% Coinsurance of UCR | Deductible then your plan pays 60% Coinsurance of UCR |

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| Pediatric Vision Benefits | 3000 | 5000 | 7000 |
|---|---|---|---|
| **Eye exam** - one every 12 months<br>• including dilation (when professionally indicated) | Your Plan pays 100% of UCR | | |
| **Lenses** one pair per member every 12 months (provided there were no benefits paid for contact lenses during the same benefit period). | Your Plan pays 100% of UCR | | |
| **Frames** one every 12 months from the Pediatric Frame Selection*<br>* If you choose a frame that is not in the Pediatric Frame Selection you will be responsible for the difference in cost between the price of the frame selected and those available in the Pediatric Frame Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums. | Your Plan pays 100% of UCR | | |
| **Contact Lenses** (instead of eye glasses) once every 12 months from the Pediatric Contact Lens Selection** including the evaluation, fitting and follow-up care (provided there were no benefits paid for contact lenses during the same benefit period).<br>** If you do not select contact lenses from the Pediatric Contact Lens Selection you will be responsible for the difference in cost between the contact lenses selected and those available in the Pediatric Contact Lens Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums. | Your Plan pays 100% of UCR | | |

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Keeping You Well, While You're Away.®

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