

INDIVIDUAL COMPREHENSIVE MEDICAL COMPARISON

	Asuris Emerge Plus	Lifewise Wise Choices Prime	Group Health Balance 1750	Emerge Core
Annual Ded. Coinsurance	\$1,000 or \$2,500; Fam x 3 20%	Ind: \$1,500; Fam: \$4,500 30%	Ind: \$1,750; Fam: \$5,250 20%	\$2,500 or \$5,000; Fam x 3 30%
Annual Co-insurance Max.	\$5,500 - Fam x 3	Ind: \$6,500; Fam: 3x Ind.	Ind: \$6,000; Fam: 3x Ind.	\$7,500 - Fam x 3
Office Visits	\$25/visit for 1st 4 visits, then subject to ded. & coinsurance	Deductible Waived \$30 Copay	Deductible Waived \$30 Copay/Visit \$50 Specialist	\$35/visit for 1st 4 visits, then subject to ded. & coinsurance
Preventive Exams, Screenings, Immunizations	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Pharmacy	\$10 generics/\$500 deductible for brand \$2,500 PCY max benefit	\$10/30%/50% Brand \$3,000 PCY limit; Generic Unlimited	\$15/40%/50% \$3,000 PCY max benefit	Prescription Discount Card Available
Outpatient Diagnostic Imaging & Lab Srv.	Deductible Waived on 1st \$400 PCY, then deductible and 20%	Deductible, then 30%	Deductible Waived on 1st \$400 PCY, then deductible and 20%	Deductible Waived on 1st \$200 PCY, then deductible and 30%
Emergency Room	\$100 Copay (waived if admitted) then deductible & 20%	\$100 Copay, then subject to deductible then 30%	\$100 Copay plus 20%	\$150 Copay (waived if admitted) then deductible & 30%
Ambulance Transportation	Deductible then 20%	Deductible then 30%	Deductible then 20%	Deductible then 30%
Alternative Care	Deductible then 20%	Deductible Waived, \$30 Copay	Deductible Waived, \$30 Copay - visits may be limited	Deductible then 30%
Inpatient/Outpatient Facility Care	Deductible then 20%	Deductible then 30%	\$300/day up to 5 days/admit + 20%	Deductible then 30%
Rehabilitation	Deductible then 20%	Deductible then 30%	\$30 Copay	Deductible then 30%
Durable Medical Equipment	Deductible then 20%	Deductible then 30%	50% up to \$5,000 (\$2,500 max benefit PCY)	Deductible then 30%
Mental Health				
<i>Outpatient</i>	Deductible then 20%	Deductible Waived, \$30 Copay	Deductible Waived, \$30 Copay	Deductible then 30%
<i>Inpatient</i>	Deductible then 20%	Deductible then 30%	\$300/day up to 5 days/admit + 20%	Deductible then 30%
Maternity Care	\$30 Copay	Deductible then 30%	\$30 Copay	Not Covered
Routine Vision Exam Hardware	\$150 Combined Benefit/Year	Covered In Full \$200 every 2 years	\$30 Copay \$200 per year	Not Covered Not Covered
RATES	Non-Smoker	Non-Smoker	Non-Smoker	Non-Smoker
<25	\$248 or \$188	\$203	\$251	\$115 or \$95
25 - 29	\$285 or \$216	\$231	\$305	\$132 or \$109
30 - 34	\$331 or \$250	\$265	\$317	\$154 or \$126
35 - 39	\$391 or \$296	\$318	\$295	\$181 or \$149
40 - 44	\$460 or \$348	\$372	\$308	\$213 or \$175
45 - 49	\$556 or \$421	\$468	\$351	\$258 or \$212
50 - 54	\$662 or \$501	\$573	\$435	\$307 or \$252
55 - 59	\$777 or \$588	\$667	\$519	\$360 or \$296
60 - 64>	\$910 or \$689	\$759	\$672	\$422 or \$347
Dependents	\$248 or \$188 per child	\$171 per child	144 per child	\$115 or \$95 per child

Please see complete plan booklets for complete benefit information including limitations. This is for comparison purposes only; and should not be construed as a contract or a representation of a contract.