SONIC HEALTH PLAN
MEDICAL BENEFIT SUMMARY

	BlueChoice			
	$500 Deductible	**$1,000 Deductible**	**$2,000 Deductible**	**$5,000 Deductible**
	PPO	**PPO**	**PPO**	**PPO**
SELECTION OF PHYSICIAN	• Nearly 3,500 doctors statewide • Nationwide access through BlueCard PPO Program	• Nearly 3,500 doctors statewide • Nationwide access through BlueCard PPO Program	• Nearly 3,500 doctors statewide • Nationwide access through BlueCard PPO Program	• Nearly 3,500 doctors statewide • Nationwide access through BlueCard PPO Program
DEDUCTIBLE	• $500 Individual • $1,500 Family	• $1,000 Individual • $3,000 Family	• $2,000 Individual • $6,000 Family	• $5,000 Individual • $15,000 Family
COINSURANCE	• 80% of allowable amount for In-Network services • 60% of allowable amount for Out-of-Network services	• 80% of allowable amount for In-Network services • 60% of allowable amount for Out-of-Network services	• 80% of allowable amount for In-Network services • 60% of allowable amount for Out-of-Network services	• 80% of allowable amount for In-Network services • 60% of allowable amount for Out-of-Network services
OUT-OF-POCKET	• $1,000 per family member for In-Network services plus deductible • $4,000 per family member for Out-of-Network services plus deductible plus charges above In-Network allowable maximum	• $2,000 per family member for In-Network services plus deductible • $8,000 per family member for Out-of-Network services plus deductible plus charges above In-Network allowable maximum	• $2,000 per family member for In-Network services plus deductible $8,000 per family member for Out-of-Network services plus deductible plus charges above In-Network allowable maximum	• $2,000 per family member for In-Network services plus deductible $8,000 per family member for Out-of-Network services plus deductible plus charges above In-Network allowable maximum
OFFICE VISITS	• **$20 Copay**	• $20 Copay	• $20 Copay	• $20 Copay
OFFICE VISITS (CHILDREN)	• **$20 Copay to age 19**	• $20 Copay to age 19	• $20 Copay to age 19	• $20 Copay to age 19
LAB/X-RAY	• **Covered in full for most services performed in conjunction with a covered office visit (other than MRI, CT, Pet Scans & other excluded services**	• **Covered in full for most services performed in conjunction with a covered office visit (other than MRI, CT, Pet Scans & other excluded services**	• **Covered in full for most services performed in conjunction with a covered office visit (other than MRI, CT, Pet Scans & other excluded services**	• **Covered in full for most services performed in conjunction with a covered office visit (other than MRI, CT, Pet Scans & other excluded services**
ADULT PREVENTIVE CARE	• **$300 Preventive Care Benefit, includes routine physicals, tests, and tetanus shots**	• **$300 Preventive Care Benefit, includes routine physicals, tests, and tetanus shots**	• **$300 Preventive Care Benefit, includes routine physicals, tests, and tetanus shots**	• **$300 Preventive Care Benefit, includes routine physicals, tests, and tetanus shots**
OTHER PHYSICIAN & MEDICAL SERVICES	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply
PRESCRIPTION DRUGS	• Plan deductible and coinsurance apply at BlueChoice pharmacies	• Plan deductible and coinsurance apply at BlueChoice pharmacies	• Plan deductible and coinsurance apply at BlueChoice pharmacies	• Plan deductible and coinsurance apply at BlueChoice pharmacies
ROUTINE GYNECOLOGICAL EXAMINATION	• **$20 Copay, then paid at 100%**	• $20 Copay, then paid at 100%	• $20 Copay, then paid at 100%	• $20 Copay, then paid at 100%
ROUTINE PAP SMEAR	• **Included with routine gynecological exam**	• **Included with routine gynecological exam**	• **Included with routine gynecological exam**	• **Included with routine gynecological exam**

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ROUTINE DRE (DIGITAL RECTAL EXAM) & PSA TEST	• **$20 Copay to In-Network specialist** *Annual screening for early detection of prostate cancer in male Subcribers age 40 or older, including a prostate-specific antigen blood test and a digital rectal examination. Limited to one screening per benefit period, not to exceed $65 per screening*	• $20 Copay to In-Network specialist *Annual screening for early detection of prostate cancer in male Subcribers age 40 or older, including a prostate-specific antigen blood test and a digital rectal examination. Limited to one screening per benefit period, not to exceed $65 per screening*	• $20 Copay to In-Network specialist *Annual screening for early detection of prostate cancer in male Subcribers age 40 or older, including a prostate-specific antigen blood test and a digital rectal examination. Limited to one screening per benefit period, not to exceed $65 per screening*	• $20 Copay to In-Network specialist *Annual screening for early detection of prostate cancer in male Subcribers age 40 or older, including a prostate-specific antigen blood test and a digital rectal examination. Limited to one screening per benefit period, not to exceed $65 per screening*
IMMUNIZATIONS	• **$20 Copay** • Copay waived for covered childhood immunizations up to age 19	• $20 Copay • Copay waived for covered childhood immunizations up to age 19	• $20 Copay • Copay waived for covered childhood immunizations up to age 19	• $20 Copay • Copay waived for covered childhood immunizations up to age 19
MAMMOGRAPHY	• $115 deductible-free benefit is provided once per year past age 40	• $115 deductible-free benefit is provided once per year past age 40	• $115 deductible-free benefit is provided once per year past age 40	• $115 deductible-free benefit is provided once per year past age 40
MATERNITY	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply
INPATIENT CARE	• Plan deductible and coinsurance apply • Additional $300 deductible per admission for Out-of-Network hospitalization	• Plan deductible and coinsurance apply • Additional $300 deductible per admission for Out-of-Network hospitalization	• Plan deductible and coinsurance apply • Additional $300 deductible per admission for Out-of-Network hospitalization	• Plan deductible and coinsurance apply • Additional $300 deductible per admission for Out-of-Network hospitalization
OUTPATIENT CARE/HOSPITAL SERVICES	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply	• Plan deductible and coinsurance apply
EMERGENCY CARE	• Plan deductible and coinsurance apply **Additional per occurrence deductible of $100 for each emergency room visit, waived if admitted**	• Plan deductible and coinsurance apply **Additional per occurrence deductible of $100 for each emergency room visit, waived if admitted**	• Plan deductible and coinsurance apply **Additional per occurrence deductible of $100 for each emergency room visit, waived if admitted**	• Plan deductible and coinsurance apply **Additional per occurrence deductible of $100 for each emergency room visit, waived if admitted**
PSYCHIATRIC CARE/ ALCOHOLISM/DRUG ABUSE	Subject to deductible, then • Inpatient: Benfits are provided at 50% for 30 days • Outpatient: Benefits are provided at 50% for 20 visits per calendar year • Coinsurance does not count toward the Out-of-Pocket limit	Subject to deductible, then • Inpatient: Benfits are provided at 50% for 30 days • Outpatient: Benefits are provided at 50% for 20 visits per calendar year • Coinsurance does not count toward the Out-of-Pocket limit	Subject to deductible, then • Inpatient: Benfits are provided at 50% for 30 days • Outpatient: Benefits are provided at 50% for 20 visits per calendar year • Coinsurance does not count toward the Out-of-Pocket limit	Subject to deductible, then • Inpatient: Benfits are provided at 50% for 30 days • Outpatient: Benefits are provided at 50% for 20 visits per calendar year • Coinsurance does not count toward the Out-of-Pocket limit
LIFETIME MAXIMUM	• $5,000,000 per person	• $5,000,000 per person	• $5,000,000 per person	• $5,000,000 per person
AGE LIMIT FOR DEPENDENT CHILDREN	• To the end of year reaching age 19 or to 23rd birthday if full-time student	• To the end of year reaching age 19 or to 23rd birthday if full-time student	• To the end of year reaching age 19 or to 23rd birthday if full-time student	• To the end of year reaching age 19 or to 23rd birthday if full-time student

This benefit summary does not contain a complete list of benefits available to you nor does it contain a listing of exclusions, limitations and conditions which apply to the benefits shown. Full information can be found only in the Group Contract and Certificate of Benefits.

For groups with more than 50 employees, please see your Group Contract and/or Certificate of Benefits for information about certain state-mandated benefits.

You may not change benefit options until your group's renewal.

You cannot choose more than one deductible option.

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	PPO	PPO	PPO	PPO

For applicable deductible credit you must submit a recent EOB from your group's previous carrier with your application. For pre-ex credit, see your account representative.