



CHAMBERS OF COMMERCE ADVANTAGE NETWORK PLANS

BENEFIT	NETWORK 1	NETWORK 2	NETWORK 3	NETWORK 4
	In Network Referred	In Network Referred	In Network Referred	In Network Referred
Deductible (Calendar Year) - Individual*	\$750	\$1,500	\$2,500	\$4,000
Deductible (Calendar Year) - Family*	\$2,250	\$4,500	\$5,000	\$8,000
Coinsurance	20%	10%	20%	20%
Out of Pocket Max (including Deductible) - Individual*	\$1,500	\$3,000	\$5,000	\$8,000
Out of Pocket Max (including Deductible) - Family*	\$4,500	\$9,000	\$10,000	\$16,000
Primary Care Physician Office Visit (PCP)	\$15	\$15	\$20	\$25
Specialty Care Physician Office Visit (SCP)	\$30	\$40	\$40	\$45
Wellness and Preventative (unlimited)	\$15	\$15	\$20	\$25
Urgent Care	20%	10%	20%	20%
Emergency Care	20%	10%	20%	20%
Inpatient Hospital Services	20%	10%	20%	20%
Outpatient Surgery Services	20%	10%	20%	20%
Maternity Care PCP/SCP	\$150/\$300	\$150/\$400	\$200/\$400	\$250/\$450
Outpatient Labs, Pathology, Radiology, (EKG) and (EEG) MRI, CT, MRA and PET scan	\$0	\$0	\$0	\$0
Allergy Serum	20%	10%	20%	20%
DME & Corrective Appliances	20%	10%	20%	20%
Mental Health Inpatient	20%	10%	20%	20%
Mental Health Outpatient	\$30	\$40	\$40	\$45
Vision (Routine Exam Only)	\$15	\$15	\$15	\$15

Where Coinsurance (%) is listed, it is assumed that Deductible is paid first. Co-pays do not count toward Deductible and Out of Pocket Max on Managed Care Plans. Most out of network and/or non-referred non-emergency benefits require you to seek prior authorization by calling the Pre-Cert phone number listed on your ID card.

*These plans are in network only and have no out of network coverage.



CHAMBERS OF COMMERCE POINT OF SERVICE PLANS (POS)

BENEFIT	POS 1		POS 2		POS 3		POS 4	
	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred
Deductible (Calendar Year) - Individual*	\$750	\$1,500	\$1,500	\$3,000	\$2,500	\$5,000	\$4,000	\$8,000
Deductible (Calendar Year) - Family*	\$2,250	\$4,500	\$4,500	\$9,000	\$5,000	\$10,000	\$8,000	\$16,000
Coinsurance	20%	40%	10%	30%	20%	40%	20%	40%
Out of Pocket Max (including Deductible) - Individual*	\$1,500	NA	\$3,000	NA	\$5,000	NA	\$8,000	NA
Out of Pocket Max (including Deductible) - Family*	\$4,500	NA	\$9,000	NA	\$10,000	NA	\$16,000	NA
Primary Care Physician Office Visit (PCP)	\$15	40%	\$15	30%	\$20	40%	\$25	40%
Specialty Care Physician Office Visit (SCP)	\$30	40%	\$40	30%	\$40	40%	\$45	40%
Wellness and Preventative (unlimited)	\$15	40%	\$15	30%	\$20	40%	\$25	40%
Urgent Care	20%	40%	10%	30%	20%	40%	20%	40%
Emergency Care	20%	NA	10%	NA	20%	NA	20%	NA
Inpatient Hospital Services	20%	40%	10%	30%	20%	40%	20%	40%
Outpatient Surgery Services	20%	40%	10%	30%	20%	40%	20%	40%
Maternity Care PCP/SCP	\$150/\$300	40%	\$150/\$400	30%	\$200/\$400	40%	\$250/\$450	40%
Outpatient Labs, Pathology, Radiology, (EKG) and (EEG) MRI, CT, MRA and PET scan	\$0	40%	\$0	30%	\$0	40%	\$0	40%
Allergy Serum	20%	40%	10%	30%	20%	40%	20%	40%
DME & Corrective Appliances	20%	NA	10%	NA	20%	NA	20%	NA
Mental Health Inpatient	20%	40%	10%	30%	20%	40%	20%	40%
Mental Health Outpatient	\$30	40%	\$40	30%	\$40	40%	\$45	40%
Vision (Routine Exam Only)	\$15	NA	\$15	NA	\$15	NA	\$15	NA

Where Coinsurance (%) is listed, it is assumed that Deductible is paid first. Co-pays do not count toward Deductible and Out of Pocket Max on Managed Care Plans. Most out of network and/or non-referred non-emergency benefits require you to seek prior authorization by calling the Pre-Cert phone number listed on your ID card. *Point of Service benefit plans are also available as in network only benefit plans.