

**THE SQUIRES GROUP, INC.**  
**Medical Benefits Summary**

	HMO HSA BLUE CHOICE OPEN ACCESS	POS HSA BLUE CHOICE OPT-OUT PLUS OPEN ACCESS		PPO HSA BLUE PREFERRED HSA	
	In-Network All services subject to deductible No Primary Care Physician Referral	In-Network No Primary Care Physician Referral	Non-Network**	In-Network	Non-Network**
		All services subject to deductible		All services subject to deductible	
<b>- OFFICE SERVICES -</b>					
Doctor Visits	\$20/\$30 PCP/SPEC	\$20/\$30 PCP/SPEC	80%	90%	70%
Well Child Care	100%	100%	0-24 mos: \$10 Copay 24 mos-13 yrs (Imm.): \$10 Copay 24 mos-13 yrs (Non-Imm.): 80% 14-17 yrs: 80% (Not subject to deductible)	100%	\$20 Copay or 70% (Not subject to deductible)
Maternity	\$20 Copay	\$20 Copay	80%	90%	70%
<b>- MAJOR MEDICAL -</b>					
Deductible Single	\$2,000	\$1,200	\$1,800	\$1,200	
Deductible Family	\$4,000	\$2,400	\$3,600	\$2,400	
Co-Insurance	100%	100%	80%	90%	70%
Out Of Pocket Single	\$4,000	\$2,400	\$3,600	\$3,400	
Out Of Pocket Family	\$8,000	\$4,800	\$7,200	\$6,800	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	
<b>- HOSPITAL CHARGES -</b>					
Room & Board	\$250 Copay per Admission + \$20/30 Physician Copay / Visit	\$250 Copay per Admission + \$20/30 Physician Copay / Visit	80%	90%	70%
Surgery	\$30 Copay - Facility \$30 Copay - Physician	\$30 Copay - Facility \$30 Copay - Physician	80%	90%	70%
Lab & X-Ray	\$30 Copay or 50% of Cost (whichever is less)	\$30 Copay or 50% of Cost (whichever is less)	80%	90%	70%
Emergency Room	\$100 Copay*	\$100 Copay*	\$100 Copay*	\$100 Copay* plus 90% (Deductible applies)	\$100 Copay* plus 90% (Deductible applies)
<b>- MENTAL HEALTH -</b>					
In-Patient Facility Limited to 60 Days Per Year	\$250 Copay per Admission \$20/\$30 Physician Copay Per Visit	\$250 Copay per Admission \$20/\$30 Physician Copay Per Visit	80%	90%	70%
Out-Patient	70%	70%	50%	80%	65%
<b>- PRESCRIPTION CARD -</b>					
Deductible	\$2,000 (Combined w/ Medical)	\$1,200 (Combined w/ Medical)	In-Network Benefit Only	\$1,200 (Combined w/ Medical)	
Generic	\$0	\$0		\$0	In-Network Benefit Only
Preferred	\$25	\$25		\$25	
Non-Preferred	\$45	\$45		\$45	

\* Waived if immediately admitted to the hospital.

\*\*For Non-Network benefits, you will also owe the difference between the provider's charges and the Plan Allowance.

The information provided within this proposal is a summary of plan benefits, provisions, and costs based upon the information received.

This information is not intended to provide a full description of plan benefits and provisions and does not supersede the information provided in the formal insurance quotes.

Rates and benefits are subject to change based on information received upon enrollment.