

Specific Plan Benefit Descriptions

CeltiCare Premier

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	Unlimited
Family total	Unlimited
Annual Deductible	Maximum amount
Per person	None
Family total	None

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$20/\$30
Office Visits (PCP/Specialists) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$20/\$30
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	\$150 per surgery
Diagnostic X-rays/Labs	\$25/\$25
Diagnostic CT/MRI/MRA/PET scan	\$100/\$100/\$100/\$100
Nuclear Cardiac Imaging	\$100
Inpatient Medical and Maternity Care	\$150 per admission
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred \$30 •Non-preferred \$50
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred \$60 •Non-preferred \$150
Emergency Care (waived if admitted)	\$75
Mental Health (biological based)	
Office visits	\$20
Inpatient Admission	\$150 per admission
Mental Health (non-biological based)	
Office visits	\$20
Inpatient Admission	\$150 per admission
Substance Abuse	
Oupatient Office Visits and rehabilitation	\$20
Oupatient detoxification	\$20
Inpatient Admission (rehabilitation)	\$150 per admission
Inpatient Admission (detoxification)	\$150 per admission
Rehabilitation Services	
Cardiac Rehabilitation	\$25
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	\$150 per admission
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	\$150 per admission

CeltiCare Solution

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$2,000
Family total	\$4,000
Annual Deductible	Maximum amount
Per person	None
Family total	None

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$25/\$25
Office Visits (PCP/Specialists) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$25/\$25
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	\$500 per surgery
Diagnostic X-rays/Labs	\$0/\$0
Diagnostic CT/MRI/MRA/PET scan	\$75/\$75/\$75/\$75
Nuclear Cardiac Imaging	\$75
Inpatient Medical and Maternity Care	\$500 per admission
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred - 50% co-insurance •Non-preferred - 50% co-insurance
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred 50% co-insurance •Non-preferred 50% co-insurance
Emergency Care (waived if admitted)	\$100
Mental Health (biological based)	-
Office visits	\$25
Inpatient Admission	\$500 per admission
Mental Health (non-biological based)	-
Office visits	\$25
Inpatient Admission	\$500 per admission
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$25
Outpatient detoxification	\$25
Inpatient Admission (rehabilitation)	\$500 per admission
Inpatient Admission (detoxification)	\$500 per admission

Rehabilitation Services	
Cardiac Rehabilitation	\$25
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	\$500 per admission
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	\$500 per admission
Short-term outpatient rehabilitation (Physical and Occupational Therapies up to a combined 60 visits per benefit year.)	\$25
Speech Therapy (no limits other than medical necessity)	\$25
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	\$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year. • No limit for DME provided during a Home Health Care Service. • No limit on Diabetic Supplies. 	\$0
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$25
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

CeltiCare Solution 500

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$2,000
Family total	\$4,000
Annual Deductible	Maximum amount
Per person	\$500
Family total	\$1,000

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$20/\$20
Office Visits (PCP/Specialists) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$20/\$20
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then \$0
Diagnostic X-rays/Labs	Deductible, then \$0
Diagnostic CT/MRI/MRA/PET scan	Deductible, then \$0
Nuclear Cardiac Imaging	Deductible, then \$0
Inpatient Medical and Maternity Care	Deductible, then \$0
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred \$35 •Non-preferred \$60
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred \$70 •Non-preferred \$120
Emergency Care (waived if admitted)	\$100
Mental Health (biological based)	-
Office visits	\$20
Inpatient Admission	Deductible, then \$0
Mental Health (non-biological based)	-
Office visits	\$20
Inpatient Admission	Deductible, then \$0
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$20
Outpatient detoxification	\$20
Inpatient Admission (rehabilitation)	Deductible, then \$0
Inpatient Admission (detoxification)	Deductible, then \$0
Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then \$20
Home Health Care	\$0
Inpatient Rehabilitation Services	

Skilled Nursing Facility (Up to 100 days per benefit year)	Deductible, then \$0
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then \$0
Short-term outpatient rehabilitation (Physical and Occupational Therapies up to a combined 60 visits per benefit year.)	Deductible, then \$20
Speech Therapy (no limits other than medical necessity)	Deductible, then \$20
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then \$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year. • No limit for DME provided during a Home Health Care Service. • No limit on Diabetic Supplies. 	Deductible, then \$0 \$15 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$20
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

CeltiCare Solution 1000

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$2,000
Family total	\$4,000
Annual Deductible	Maximum amount

Per person	\$1,000
Family total	\$2,000

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$20/\$20
Office Visits (PCP/Specialists) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$20/\$20
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then \$0
Diagnostic X-rays/Labs	Deductible, then \$0
Diagnostic CT/MRI/MRA/PET scan	Deductible, then \$0
Nuclear Cardiac Imaging	Deductible, then \$0
Inpatient Medical and Maternity Care	Deductible, then \$0
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred \$30 •Non-preferred \$50
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred \$60 •Non-preferred \$150
Emergency Care (waived if admitted)	Deductible, then \$100
Mental Health (biological based)	
Office visits	\$20
Inpatient Admission	Deductible, then \$0
Mental Health (non-biological based)	
Office visits	\$20
Inpatient Admission	Deductible, then \$0
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$20
Outpatient detoxification	\$20
Inpatient Admission (rehabilitation)	Deductible, then \$0
Inpatient Admission (detoxification)	Deductible, then \$0
Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then \$20
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (up to 100 days per benefit year)	Deductible, then \$0
Inpatient Rehabilitation or Chronic Disease Hospital (up to 60 days per benefit year)	Deductible, then \$0
Short-term outpatient rehabilitation (Physical and Occupational, Therapies up to a combined 60 visits per benefit year.)	Deductible, then \$20

Speech Therapy (no limits other than medical necessity)	Deductible, then \$20
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then \$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined Limit of \$1,000 per benefit year. • No limit for DME provided during a Home Health Care Service. • No limit on Diabetic Supplies. 	Deductible, then \$0 \$15 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$20
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

CeltiCare Saver 250

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$5,000
Family total	\$10,000
Annual Deductible	Maximum amount
Per person	\$250
Family total	\$500
Prescription Drug (For Retail and Mail Order Preferred and Non-preferred)	\$250 per individual, \$500 per family

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$25/\$40
Office Visits (PCP/Specialists) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$25/\$40
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then 35% coinsurance
Diagnostic X-rays/Labs	Deductible, then 35% co-insurance
Diagnostic CT/MRI/MRA/PET scan	Deductible, then 35% co-insurance
Nuclear Cardiac Imaging	Deductible, then 35% co-insurance
Inpatient Medical and Maternity Care	Deductible, then 35% co-insurance
Prescription Drugs	
Medication via Retail Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred – RX deductible, then 50% co-insurance •Non-preferred - RX deductible, then 50% co-insurance
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred - RX deductible, then 50% co-insurance •Non-preferred- RX deductible, then 50% co-insurance
Emergency Care (waived if admitted)	\$150
Mental Health (<i>biological based</i>)	-
Office visits	\$25
Inpatient Admission	Deductible, then 35% coinsurance

Mental Health (<i>non-biological based</i>)	-
Office visits	\$25
Inpatient Admission	Deductible, then 35% coinsurance
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$25
Outpatient detoxification	\$25
Inpatient Admission (rehabilitation)	Deductible, then 35% coinsurance
Inpatient Admission (detoxification)	Deductible, then 35% coinsurance
Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then 35% coinsurance
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	Deductible, then 35% coinsurance
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then 35% coinsurance
Short-term outpatient rehabilitation (Physical and Occupational Therapies up to a combined 60 visits per benefit year.)	Deductible, then 35% coinsurance
Speech Therapy (no limits other than medical necessity)	Deductible, then 35% coinsurance
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then 35% co-insurance
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limited of \$1,000 per benefit year. • No limit for DME provided during a Home Health Care Service. • No limit on Diabetic Supplies. 	Deductible, then 35% coinsurance \$15 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$15
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

CeltiCare Saver 2000

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$5,000
Family total	\$10,000
Annual Deductible	Maximum amount
Per person	\$2,000
Family total	\$4,000
Prescription Drug (For Retail and Mail Order Preferred and Non-preferred)	\$250 per individual, \$500 per family

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$30/\$45
Office Visits (PCP/Specialists) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	\$30/\$45
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then \$250 per surgery
Diagnostic X-rays/Labs	Deductible, then \$0
Diagnostic CT/MRI/MRA/PET scan	Deductible, then \$0
Nuclear Cardiac Imaging	Deductible, then \$0
Inpatient Medical and Maternity Care	Deductible, then \$500 per admission
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$10 •Preferred-RX deductible, then \$30 •Non-preferred-RX deductible, then \$50
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$20 •Preferred-RX deductible, then \$60 •Non-preferred-RX deductible, then \$90
Emergency Care (waived if admitted)	Deductible, then \$150
Mental Health (biological based)	-
Office visits	\$30
Inpatient Admission	Deductible, then \$500 per admission
Mental Health (non-biological based)	-

Office visits	\$30
Inpatient Admission	Deductible, then \$500 per admission
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$30
Outpatient detoxification	\$30
Inpatient Admission (rehabilitation)	Deductible, then \$500 per admission
Inpatient Admission (detoxification)	Deductible, then \$500 per admission
Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then \$30
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility(Up to 100 days per benefit year)	Deductible, then \$500 per admission
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then \$500 per admission
Short-term outpatient rehabilitation (Physical and Occupational Therapies up to a combined 60 visits per benefit year.)	Deductible, then \$30
Speech Therapy (no limits other than medical necessity)	Deductible, then \$30
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then \$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year. • No limit for DME provided during a Home Health Care Service. • No limit on Diabetic Supplies. 	Deductible, then \$0 \$10 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$30
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

CeltiCare Saver HSA

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$5,000
Family total	\$10,000

Annual Deductible	Maximum amount
Per person	\$2,000
Family total	\$4,000

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	Deductible then \$25/ Deductible then \$25
Office Visits (PCP/Specialists) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	Deductible then \$25/ Deductible then \$25
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then 20% coinsurance
Diagnostic X-rays/Labs	Deductible, then 20% coinsurance
Diagnostic CT/MRI/MRA/PET scan	Deductible, then 20% coinsurance
Nuclear Cardiac Imaging	Deductible, then 20% coinsurance
Inpatient Medical and Maternity Care	Deductible, then 20% coinsurance
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* Deductible, then \$15 •Preferred- Deductible, then 50% coinsurance •Non-preferred- Deductible, then 50% coinsurance
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* Deductible, then \$30 •Preferred Deductible, then 50% coinsurance •Non-preferred Deductible, then 50% coinsurance
Emergency Care (waived if admitted)	Deductible, then \$100
Mental Health (biological based)	-
Office visits	Deductible, then \$25
Inpatient Admission	Deductible, then 20%

	coinsurance
Mental Health (<i>non-biological based</i>)	-
Office visits	Deductible, then \$25
Inpatient Admission	Deductible, then 20% coinsurance
Substance Abuse	
Outpatient Office Visits and rehabilitation	Deductible, then \$25
Outpatient detoxification	Deductible, then \$25
Inpatient Admission (rehabilitation)	Deductible, then 20% coinsurance
Inpatient Admission (detoxification)	Deductible, then 20% coinsurance
Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then 20% coinsurance
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	Deductible, then 20% coinsurance
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then 20% coinsurance
Short-term outpatient rehabilitation (Physical and Occupational Therapies up to a combined 60 visits per benefit year)	Deductible, then 20% coinsurance
Speech Therapy (no limits other than medical necessity)	Deductible, then 20% coinsurance
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then 20% coinsurance
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year. • No limit for DME provided during a Home Health Care Service. • No limit on Diabetic Supplies. 	Deductible, then 20% coinsurance Deductible, then \$15 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$25
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0