

LocalSelect Consumers Plans (Non-Grandfathered)											
LocalSelect™		Consumers Basic 1000		Consumers Basic 2000		Consumers Preferred 3000		Consumers Basic 3000		Consumers Preferred 5000	
Basics	Deductible - Individual In-Network	\$1,000	\$2,000	\$3,000	\$3,000	\$5,000					
	Deductible - Individual Out-of-Network	\$2,500	\$3,500	\$5,000	\$5,000	\$8,000					
	Coinsurance - In-Network (%)	70/30	70/30	80/20	70/30	80/20					
	Coinsurance - Out-of-Network (%)	50/50	50/50	60/40	50/50	60/40					
	Maximum Out-of-Pocket - Individual In-Network	\$4,000	\$4,500	\$5,000	\$5,000	\$7,500					
	Maximum Out-of-Pocket - Individual Out-of-Network	\$5,500	\$6,500	\$10,000	\$10,000	\$12,500					
Copays	Preventive Care Copays										
	Routine Physical Exams (including testing)	\$0	\$0	\$0	\$0	\$0					
	Annual GYN Exams	\$0	\$0	\$0	\$0	\$0					
	Routine Well-Child Care	\$0	\$0	\$0	\$0	\$0					
	Child and Adult Immunizations	\$0	\$0	\$0	\$0	\$0					
	Screening Mammogram / Screening Colonoscopy	\$0	\$0	\$0	\$0	\$0					
	Other PPACA covered Preventive Care Services	\$0	\$0	\$0	\$0	\$0					
Diagnostic Mammogram (to examine abnormalities)	\$100	\$100	\$100	\$100	\$100						
Deductible / Coinsurance Applies	Office Visits										
	PCP	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Mental Health/Substance Abuse	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Specialist	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Lab Tests and Bloodwork	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Other Services Performed in Office	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Routine Allergy Injections	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Maternity Care										
	Outpatient pre- and post-natal Office Visits	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Routine Urinalysis and Bloodwork	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Diagnostic Tests and Ultrasounds	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Inpatient Maternity Care / Delivery	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Urgent Care Office Visit / Other Services Performed during Visit	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Chiropractic Services (Spinal Manipulation \$500 Limit)	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Hospital Expenses - Inpatient	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Hospital Expenses - Outpatient/Facility Testing	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
	Medical/Surgical Expenses	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
Durable Medical Equipment (\$2000 Limit)	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%						
Ground Ambulance (\$3000 Limit)	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%						
Mental Health/Substance Abuse											
Hospital - Inpatient/Outpatient/Partial Day Visits	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%						
Skilled Nursing Facility Care (100 day limit)	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%						
Home Health Care (90 day limit)	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%						
Hospice	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%						
ER	Emergency Room Services	Ded/30%	Ded/30%	Ded/20%	Ded/30%	Ded/20%					
Pharmacy	Retail Program (90 Day Mail Order is 2X Retail)										
	Two-Tier										
	\$10/\$20						Preferred				
	\$15/\$30						Basic				
	\$15/\$40										
	\$15/\$30 (\$150 Ded.)										
	\$10/\$20/\$35 or 20%										
\$10/\$30/\$50											
\$10/\$30/\$50 or 20%											
\$10/\$40/\$55											
\$15/\$40/\$55											



This is only a brief description of benefits for comparison purposes only. A complete description is provided through the appropriate Certificate of Coverage, Schedule of Benefits, and any Amendments to the policy.