

Medical Benefit Template

Medical Benefit Information	Please try to follow the standardized plan descriptions provided. Please provide plan names and benefits as they should appear on our site. If you feel more pertinent information is required in the benefit description, type the additional information in red font and we will try to accommodate your request. Do not add or remove rows. This document mirrors the "Benefit Details" on our site and must remain consistent for all carriers.	This Column is to be utilized as an example				
	Standardized Plan Descriptions	Example	Plan # 1	Plan # 2	Plan # 3	Plan # 4
Plan Name		PPO Value 1500				
Primary Care Physician Required	Y/N	N				
Specialist Referrals Required	Y/N	N				
HSA Eligible	Y/N	Y				
Out-of-Network Coverage	Y/N	N				
Out-of-Country Coverage	Y/N (Add brief description)	Y - Emergency Care Only or Y - Paid at Out-of-Network benefit level				
Admin Fees	Choose one: None \$X Monthly	None				
Plan Type	INDEMNITY, PPO, POS, EPO, HMO	PPO				
Deductible	Choose one: None \$X Individual/\$X Family	\$500 Individual/\$1500 Family				
Coinsurance	Choose one: None X% after deductible X% before deductible	25% after deductible				
Out of Pocket Limit	Choose one: None \$X Individual/\$X Family Choose one: Includes deed. Does not include ded.	\$1500 Individual/\$3000 Family (Includes deductible)				
Office Visit						

	Standardized Plan Descriptions	Example	1	2	3	4
Primary Doctor	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	25% Coinsurance after deductible				
Specialist	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	25% Coinsurance after deductible				
Periodic Health Exam	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	\$50 Copay				

	Standardized Plan Descriptions	Example	1	2	3	4
Periodic OB-GYN Exam	<i>Choose one:</i> Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	No Charge				
Well Baby Care	<i>Choose one:</i> Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	No Charge				
Chiropractic	<i>Choose one:</i> Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible <i>Choose one (if applicable):</i>	25% Coinsurance after deductible. 24 Visits Per Year./\$25 Max. Per Visit				
Mental Health	<i>Choose one:</i> Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible <i>Choose one (if applicable)</i>	25% Coinsurance after deductible. 12 Visits Per Year				
Prescription Rx						
Prescription Drugs (Generic)	<i>Choose one:</i> Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	\$20 Copay				
Prescription Drugs (Brand)	<i>Choose one:</i> Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	\$40 Copay				

	Standardized Plan Descriptions	Example	1	2	3	4
Prescription Drugs (Non-Formulary)	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	Not Covered				
Prescription Drugs (Annual deductible)	Choose one: None \$X Individual/\$X Family Medical Plan Deductible Applies Applies to: Generic and/or Brand and/or Non-Formulary	\$1,000 Individual. Applies to Brand and Non-formulary				
Mail Order (Generic)	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	\$10 Copay				
Mail Order (Brand)	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	\$25 Copay				
Mail Order (Non-Formulary)	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	Not Covered				
Mail Order (Annual Deductible)	Choose one: None \$X Individual/\$X Family Medical Plan Deductible Applies Applies to: Generic and/or Brand and/or Non-Formulary	\$750 Individual. Applies to Brand and Non-formulary				
Other						

	Standardized Plan Descriptions	Example	1	2	3	4
Lab/X-Ray	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	25% Coinsurance after deductible				
Emergency Room	Choose one: Not Covered No Charge \$X Copay No charge (after deductible) X% Coinsurance after deductible X% Coinsurance before deductible Continuation of benefit description (if applicable): Plus \$X coinsurance after deductible Plus \$X Coinsurance before	\$100 Copay plus 25% Coinsurance after deductible (waived if admitted)				
Outpatient Surgery	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible	25% Coinsurance after deductible				
Hospitalization	Choose one: Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible Choose (If applicable): Per Admission/ Per Day Maximum Stay X Days	25% Coinsurance after deductible				
Out-of-Network Coverage						

	Standardized Plan Descriptions	Example	1	2	3	4
Out-of-Network authorization required						
Is Out-of-Network Coverage Different than In-Network Coverage?						
Out-of-Network Individual/Family Deductible						
Out-of-Network Coinsurance						
Out-of-Network Individual/Family Annual Out-of-Pocket Limit						
Substance Abuse Coverage						
Pre & Postnatal office Visit	<div>Choose one:</div> <div>Not Covered No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible</div> <div>No Charge</div>	Not Covered				

	Standardized Plan Descriptions	Example	1	2	3	4
Labor & Delivery Hospital Stay	<i>Choose one:</i> Not Covered No Charge No Charge after deductible \$X Copay X% Coinsurance after deductible X% Coinsurance before deductible <i>Choose (if applicable):</i> Per Admission/ Per Day Maximum Stay X Days	Not Covered				

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Medical Benefit Information								
	Plan #	Plan #	Plan #	Plan #	Plan #	Plan #	Plan #	Plan #
	5	6	7	8	9	10	11	12
Plan Name								
Primary Care Physician Required								
Specialist Referrals Required								
HSA Eligible								
Out-of-Network Coverage								
Out-of-Country Coverage								
Admin Fees								
Plan Type								
Deductible								
Coinsurance								
Out of Pocket Limit								
Office Visit								

	5	6	7	8	9	10	11	12
Primary Doctor								
Specialist								
Periodic Health Exam								

	5	6	7	8	9	10	11	12
Periodic OB-GYN Exam								
Well Baby Care								
Chiropractic								
Mental Health								
Prescription Rx								
Prescription Drugs (Generic)								
Prescription Drugs (Brand)								

	5	6	7	8	9	10	11	12
Prescription Drugs (Non-Formulary)								
Prescription Drugs (Annual deductible)								
Mail Order (Generic)								
Mail Order (Brand)								
Mail Order (Non-Formulary)								
Mail Order (Annual Deductible)								
Other								

	5	6	7	8	9	10	11	12
Lab/X-Ray								
Emergency Room								
Outpatient Surgery								
Hospitalization								
Out-of-Network Coverage								

	5	6	7	8	9	10	11	12
Out-of-Network authorization required								
Is Out-of-Network Coverage Different than In-Network Coverage?								
Out-of-Network Individual/Family Deductible								
Out-of-Network Coinsurance								
Out-of-Network Individual/Family Annual Out-of-Pocket Limit								
Substance Abuse Coverage								
Pre & Postnatal office Visit								

	5	6	7	8	9	10	11	12
Labor & Delivery Hospital Stay								