Significa QHDHP Options AZ and OH

Individual (I) Family (F)

QHDHP Plans		Deductible (Embedded[2])		Coinsurance		Out-of-Pocket Maximum (Deductible + Coinsurance)		Office Visit Cost	
		Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred
QHDHP 1500 (Aggregate[1])	Option 1	$1,500 $3,000	$3,000 I $6,000 F	100%	80%	$1,500 $3,000	$10,000 I $20,000 F	100%	80%
	Option 2	$1,500 $3,000	$3,000 I $6,000 F	80%	60%	$5,000 $10,000	$10,000 I $20,000 F	80%	60%
QHDHP 2500	Option 1	$2,500 $5,000	$5,000 I $10,000 F	100%	80%	$2,500 $5,000	$10,000 I $20,000 F	100%	80%
	Option 2	$2,500 $5,000	$5,000 I $10,000 F	80%	60%	$5,000 $10,000	$10,000 I $20,000 F	80%	60%
QHDHP 3000	Option 1	$3,000 $6,000	$6,000 I $12,000 F	100%	80%	$3,000 $6,000	$10,000 I $20,000 F	100%	80%
	Option 2	$3,000 $6,000	$6,000 I $12,000 F	80%	60%	$5,000 $10,000	$10,000 I $20,000 F	80%	60%
QHDHP 4000	Option 1	$4,000 $8,000	$8,000 I $16,000 F	100%	80%	$4,000 $8,000	$10,000 I $20,000 F	100%	80%
	Option 2	$4,000 $8,000	$8,000 I $16,000 F	80%	60%	$5,000 $10,000	$10,000 I $20,000 F	80%	60%
QHDHP 5000	Option 1	$5,000 $10,000	$10,000 I $20,000 F	100%	100%	$5,000 $10,000	$10,000 I $20,000 F	100%	100%

Benefits are limited to a $5,000,000 lifetime maximum.

Preventive Care Services
(Service limitations may apply)

Child Care (deductible waived)
Well child office visits
Pediatric immunizations
Routine vision exam
Routine hearing exam

Routine Physical Exam (deductible waived)
Routine Screenings (deductible waived up to $500)
Includes lab testing and screenings, such as:
- Colon screening (colonoscopy);
- Osteoporosis screening;
- Prostate screening; PSA testing

Women's Health (deductible waived)
Routine gynecological exam
Cervical cancer screening (Pap)
Mammography screening

Additional Covered Services

Ambulance
Chiropractic care
Durable medical equipment
Emergency care
Home health care
Home infusion therapy
Hospice
Inpatient hospital services
Lab tests / X-rays / Imaging
Maternity
Mental health
Medical / Accident
Outpatient surgery
Physical / Speech / Occupational therapy
Rehabilitation therapy
Respiratory therapy
Skilled nursing facility
Substance abuse

Prescription Drug Options

Prescription Card	Deductible + Coinsurance, Retail and Mail Order	No drug coverage when obtained from Non-Preferred providers (out of network)

Exclusions and limitations may apply. Refer to the Group Policy for a complete listing of covered services, exclusions and limitations.

[1] **Aggregate Family Deductible** – Before benefits begin for anyone in the family, the Family Deductible amount must be met.

[2] **Embedded Family Deductible** – Benefits begin for an individual family member once that member meets the Individual Deductible amount or once the Family Deductible is met, whichever comes first.