

Specialist visit	Other practitioner office visit	Preventive care/screening/immunization
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Covered
Covered	Available for Additional Premium	Covered

Diagnostic test (x-ray, blood work)	Imaging (CT/PET scans, MRIs)	Generic drugs
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Covered
Covered	Covered	Covered

Preferred brand drugs	Non-preferred brand drugs	Specialty drugs (e.g., chemotherapy)
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Covered
Covered	Covered with Limitations	Covered

Outpatient facility fee (example, ambulatory surgery center)	Outpatient Physician/ surgeon fees	Emergency room services
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Covered
Covered	Covered	Covered

Emergency medical transportation	Urgent care	Hospitalization facility fee (example: hospital room)
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Covered
Covered	Covered	Covered

Hospitalization Physician/surgeon fee	Mental/Behavioral health outpatient services	Mental/ Behavioral health inpatient services
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Covered
Covered	Covered	Not Covered

Substance use disorder outpatient services	Substance use disorder inpatient services	Prenatal and postnatal care
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Covered
Available for Additional Premium	Covered with Limitations	Covered

Delivery and all inpatient services	Home health care	Rehabilitation services
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Covered
Covered	Covered	Covered

Habilitation services	Skilled nursing care	Durable medical equipment
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Covered	Not Covered
Available for Additional Premium	Not Covered	Not Covered

Hospice service	Eye exam	Glasses
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Covered	Not Covered	Not Covered
Available for Additional Premium	Not Covered	Not Covered

Dental check-up	Acupuncture	Bariatric Surgery
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Not Covered	Not Covered	Not Covered
Not Covered	Not Covered	Not Covered

Non-emergency care when travelling outside the U.S.	Chiropractic Care	Cosmetic Surgery
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Not Covered	Not Covered	Not Covered
Not Covered	Not Covered	Not Covered

Dental care (adult)	Hearing aids	Infertility treatment
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Not Covered	Not Covered	Not Covered
Not Covered	Not Covered	Not Covered

Long-term care	Private-duty nursing	Routine eye care (adult)
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Not Covered	Not Covered	Not Covered
Not Covered	Not Covered	Not Covered

Routine foot care	Weight loss programs
Covered, Not Covered, Available for Additional Premium, Covered with Limitations	Covered, Not Covered, Available for Additional Premium, Covered with Limitations
Not Covered	Not Covered
Not Covered	Not Covered

PLAN_TYPE	Choice	Availability	Deductible_List
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INDEMNITY	Y	Covered	None
PPO	N	Not Covered	X, X, X, X,...

POS		Covered with Limitations Available for Additional Premium	
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EPO			
HMO			

Instructions

Instructions

Covered, Not Covered,
Available for Additional
Premium, Covered with
Limitations

Enter the available deductibles separated by
commas (ex 1000, 2000, 2500, etc.)

Copay_Range	Coinsurance_Range	Annual Medical Out of P	Annual Medical Out of P OOP_Includes
None x, y	None x%, y%	None x, y	None Deductible Copay Coinsurance Coinsurance + Copay Deductible + Copay Deductible + Coinsuranc Deductible + Coinsurance + Copay
Instructions	Instructions	Instructions	Instructions
Enter the minimum and maximum copay separated by commas (ex 0, 50)	Enter the minimum and maximum coinsurance separated by commas (ex 0%, 40%)	Enter the annual medical out of pocket maximums, separated by commas.	Enter what elements are calculated for OOP in column L
Copays range from \$X to \$Y	Coinsurance ranges from X% to Y%		

Annual Max Benefit

Cost_Combo

None

\$X Deductible/ \$X Copay/ X%
Coinsurance/ \$X Max Annual
Out of Pocket

x

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Instructions

Enter the highest
annual max benefit