

Tonik Benefits



Tonik	\$1,500 -- Calculated Risk Taker	\$3,000 -- Part-time Daredevil	\$5,000 -- Thrill Seeker
Lifetime Maximum - In- and out-of-network benefits combined	\$5,000,000	\$5,000,000	\$5,000,000
Calendar Year Deductible - One per subscriber -- Single coverage only contract			
* In-network and Out-of Network Combined	\$1,500	\$3,000	\$5,000
Coinsurance			
* In-network	Plan pays 100%	Plan pays 100%	Plan pays 100%
* Out-of-network	Plan pays 70%	Plan pays 70%	Plan pays 70%
Calendar Year Out-of-Pocket Maximum	Amounts satisfied toward the Out-of-Network Out-of-Pocket will also be applied toward the In-Network Out-of-Pocket Limit. Amounts satisfied toward the In-Network Out-of-Pocket will not be applied toward the Out-of-Network Out-of-Pocket Limit.		
* In-network (includes Calendar Year Deductible)	\$1,500	\$3,000	\$5,000
* Out-of-Network (in addition to the Calendar Year Deductible)	\$10,000	\$10,000	\$10,000
Physician office visit - Includes x-ray and lab work and other office services when performed in the physician's office		(Four total office visits per year are covered as listed below for these two plans - Physician Office Visit or Preventive Care combined)	
* In-network	\$40 Copay (not subject to ded, however, the copayment will continue to be required after the deductible is met)	\$30 Copay for first 4 office visits in a calendar year then member pays negotiated fee rate until the deductible is met at which time benefits are payable at 100% with no copay.	\$20 Copay for first 4 office visits in a calendar year then member pays negotiated fee rate until the deductible is met at which time benefits are payable at 100% with no copay.
* Out-of-network (subject to balance billing)	70% of eligible charges, (not subject to ded)	70% of eligible charges for the first 4 visits in a calendar year not subject to deductible. Member pays all charges for subsequent visits until the deductible is met. Once the deductible is met the plan pays 70% of eligible charges.	70% of eligible charges for the first 4 visits in a calendar year not subject to deductible. Member pays all charges for subsequent visits until the deductible is met. Once the deductible is met the plan pays 70% of eligible charges.
Preventive Care Age 6 through Adults (Including but not limited to GA mandated benefits, periodic health assessments, immunizations, flu injections)		(Four total office visits per year are covered as listed below for these two plans - Physician Office Visit or Preventive Care combined)	
* In-network	\$40 Copayment per office visit (not subject to deductible). Services without an office visit are payable at 100% after the deductible is met.	\$30 copay per office visit for the first 4 office visits in a calendar year. Subsequent visits are payable at 100% after the deductible is met. Services without an office visit are payable at 100% after the deductible is met.	\$20 copay per office visit for the first 4 visits in a calendar year. Subsequent office visits are payable at 100% after the deductible is met. Services without an office visit are payable at 100% after the deductible is met.
* Out-of-network (subject to balance billing)	70% of eligible charges per office visit, (not subject to deductible). Services without an office visit are payable at 70% of eligible charges after the deductible is met.	70% of eligible charges per office visit for the first 4 visits in a calendar year (not subject to deductible). Subsequent visits are payable at 70% of eligible charges after the deductible is met. Services without an office visit are payable at 70% of eligible charges after the deductible is met.	70% of eligible charges per office visit for the first 4 visits in a calendar year (not subject to deductible). Subsequent visits are payable at 70% of eligible charges after the deductible is met. Services without an office visit are payable at 70% of eligible charges after the deductible is met.

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Preventive Care Children age 5 and Under <i>(includes periodic health assessments, development assessment, age appropriate immunizations, laboratory testing)</i>	Not subject to Deductible		
* In-network	\$40 copay	\$30 copay	\$20 copay
* Out-of-network <i>(subject to balance billing)</i>	70% of eligible charges per office visit	70% of eligible charges per office visit	70% of eligible charges per office visit
Professional Services -- Lab, X-ray, Surgery, Radiation, Anesthesia			
* In-network	100%	100%	100%
* Out-of-network <i>(subject to balance billing)</i>	70% of eligible charges	70% of eligible charges	70% of eligible charges
Outpatient Hospital Services/Ambulatory Surgery Center			
* In-network	100%	100%	100%
* Out-of-network <i>(subject to balance billing)</i>	pays \$380 per day toward eligible charges	pays \$380 per day toward eligible charges	pays \$380 per day toward eligible charges
Maternity			
* In-network	Not Covered	Not Covered	Not Covered
* Out-of-network			
Hospital Inpatient Services			
* In-network	100%	100%	100%
* Out-of-network <i>(subject to balance billing)</i>	pays \$650 per day toward eligible charges	pays \$650 per day toward eligible charges	pays \$650 per day toward eligible charges
Ambulance Service -- Land			
* In-network	\$1,000 per trip maximum	\$1,000 per trip maximum	\$1,000 per trip maximum
* Out-of-network			
Ambulance Service -- Air			
* In-network	\$5,000 per trip maximum	\$5,000 per trip maximum	\$5,000 per trip maximum
* Out-of-network			
Physical Therapy, Occupational Therapy, Chiropractic Services			
* In-network	100%	100%	100%
* Out-of-network <i>(subject to balance billing)</i>	pays \$25 per visit of eligible charges	pays \$25 per visit of eligible charges	pays \$25 per visit of eligible charges
<i>Visits per year, combined specialties. In- and out-of-network combined.</i>	12 / 24 for limited diagnoses	12 / 24 for limited diagnoses	12 / 24 for limited diagnoses
Limited Diagnosis: Post Neurological Surgery, Orthopedic Surgery, Cerebral Vascular Accident (stroke), Third Degree Burns, Head Trauma, Spinal Cord Injury.			
Speech Therapy			
* In-network	100%	100%	100%
* Out-of-network <i>(subject to balance billing)</i>	70% of eligible charges	70% of eligible charges	70% of eligible charges
<i>Number of visits per year, in- and out-of-network combined</i>	50	50	50
Skilled Nursing Facility Care			
* In-network	100%	100%	100%
* Out-of-network <i>(subject to balance billing)</i>	\$150 payable per day toward eligible charges	\$150 payable per day toward eligible charges	\$150 payable per day toward eligible charges
<i>Number of visits per year, in- and out-of-network combined</i>	100	100	100
Radiation Therapy/Chemotherapy			
* In-network	100%	100%	100%
* Out-of-network <i>(subject to balance billing)</i>	70% of eligible charges	70% of eligible charges	70% of eligible charges

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Mental Health/Substance Abuse			
* Inpatient -- in- and out-of-network combined (same benefit except that OON is subject to balance billing)	\$100 payable per day toward eligible charges, \$3,000 yearly max	\$100 payable per day toward eligible charges, \$3,000 yearly max	\$100 payable per day toward eligible charges, \$3,000 yearly max
* Outpatient -- in- and out-of-network combined (same benefit except that OON is subject to balance billing)	\$30 payable per visit toward eligible charges, 12 visit yearly max	\$30 payable per visit toward eligible charges, 12 visit yearly max	\$30 payable per visit toward eligible charges, 12 visit yearly max
Emergency Room			
* Medical Emergency or Accident (in and out-of-network)			
* In-network	\$100 copay, not subject to deductible, then 100% of eligible charges	\$100 copay, not subject to deductible, then 100% of eligible charges	\$100 copay, not subject to deductible, then 100% of eligible charges
* Out-of-network (subject to balance billing)	\$100 copay, not subject to deductible, then 100% of eligible charges	\$100 copay, not subject to deductible, then 100% of eligible charges	\$100 copay, not subject to deductible, then 100% of eligible charges
* Non-Medical Emergency or Non-Serious Accidental Injury			
* In-network	\$100 copay, subject to deductible, then 100% of eligible charges	\$100 copay, subject to deductible, then 100% of eligible charges	\$100 copay, subject to deductible, then 100% of eligible charges
* Out-of-network (subject to balance billing)	\$100 copay, subject to deductible, then 70% of eligible charges	\$100 copay, subject to deductible, then 70% of eligible charges	\$100 copay, subject to deductible, then 70% of eligible charges
Home Health Care			
* In-network	100%	100%	100%
* Out-of-network (subject to balance billing)	\$75 payable per visit toward eligible charges	\$75 payable per visit toward eligible charges	\$75 payable per visit toward eligible charges
Number of visits per year (in- and out-of-network combined)	60	60	60
Hospice Care			
\$10,000 Lifetime Maximum included in total Maximum (in- and out-of-network combined, Not subject to Deductible)			
* In-network	100%	100%	100%
* Out-of-network (subject to balance billing)	70% of eligible charges	70% of eligible charges	70% of eligible charges
Durable Medical Equipment and Prosthetics			
* In-network	100%	100%	100%
* Out-of-network (subject to balance billing)	70% of eligible charges	70% of eligible charges	70% of eligible charges
Private Duty Nursing			
* In-network and Out-of-network		Not Covered	
Prescription Drugs			
Same benefit for In-network and Out-of-Network			
* Generic Prescription Drugs Copay <i>Not subject to the deductible</i>	Lesser of cost or \$10	Lesser of cost or \$10	Lesser of cost or \$10
* Calendar Year Drug Deductible for Brand Name Drugs applies per calendar year in addition to the Medical Calendar Year Deductible	\$2,000	\$2,000	\$2,000
* Brand Name Preferred Drugs Copay	\$30	\$30	\$30
* Brand Name Non-Preferred Drugs Copay	\$50	\$50	\$50
Mail Order Pharmacy			
Same benefit for In-network and Out-of-Network			
* Generic Prescription Drugs	\$10 copay for 30-day supply \$20 copay for 60-day supply	\$10 copay for 30-day supply \$20 copay for 60-day supply	\$10 copay for 30-day supply \$20 copay for 60-day supply
* Brand Name Preferred Drugs Copay	\$30 copay for 30-day supply \$60 copay for 60-day supply	\$30 copay for 30-day supply \$60 copay for 60-day supply	\$30 copay for 30-day supply \$60 copay for 60-day supply
* Brand Name Non-Preferred Drugs Copay	\$50 copay for 30-day supply \$100 copay for 60-day supply	\$50 copay for 30-day supply \$100 copay for 60-day supply	\$50 copay for 30-day supply \$100 copay for 60-day supply

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Smoking Cessation			
<i>In- and out-of-network combined - Not subject to Deductible</i>	\$50 lifetime maximum	\$50 lifetime maximum	\$50 lifetime maximum
Dental			
<i>*Annual Deductible - In-network and Out-of-Network</i>	\$25	\$25	\$25
<i>*Annual Maximum Benefit - In-network and Out-of-Network</i>	\$500	\$500	\$500
*Preventive and Diagnostic (Teeth cleaning, routine exams, x-rays)	• Pay \$0 at Participating Dentists. Deductible does not apply to preventive and diagnostic services when performed by a Participating Dentist. At Non-Participating Dentists you will be responsible for the amount that exceeds the Benefit Schedule amount, in addition to the deductible.		
*Minor Restorative (fillings)	• Pay 20% at Participating Dentists after the deductible is met. At Non-Participating Dentists you will be responsible for the amount that exceeds the Benefit Schedule amount, in addition to the deductible.		
Vision			
* In-network and Out-of-network combined benefit	\$50	\$50	\$50
Waiting Period for Pre-existing Conditions			
A pre-existing waiting period may apply up to twelve (12) months under this contract after the policy start date unless covered by eligible health insurance before this policy. The 12-month waiting period may not apply or the waiting period may be shorter than the entire twelve (12) months.			
Unless otherwise specified, no benefits are payable until the calendar year deductible is satisfied.			