

PLAN NUMBER	PPO 90		PPO 80		WELLNESS PPO	
GENERAL PLAN INFORMATION	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹
Annual Medical Out-of-Pocket Limit²						
Individual/Individual in Family/Family	\$2,000/\$2,000/\$6,000	Unlimited	\$3,000/\$3,000/\$9,000	Unlimited	\$5,000/\$5,000/\$12,700	Unlimited
Annual Medical Deductible² - Plan Deductible Applies Unless Otherwise Stated						
Individual/Individual in Family/Family	\$500/\$500/\$1,500	\$1,000/\$1,000/\$3,000	\$750/\$750/\$2,250	\$1,500/\$1,500/\$4,500	\$1,250/\$1,250/\$3,750 ³	\$2,500/\$2,500/\$7,500 ³
Coinsurance, After Deductible is Met						
Plan Pays:	90% (After Deductible)	50% Coinsurance (After Deductible)	80% (After Deductible)	50% Coinsurance (After Deductible)	70% (After Deductible)	50% Coinsurance (After Deductible)
Physician/Diagnostic Services						
Preventive Care	\$0 (Deductible Waived)	Not Covered	\$0 (Deductible Waived)	Not Covered	\$0 (Deductible Waived)	Not Covered
Primary Care Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Specialist Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$40 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Diagnostic X-Ray and Lab Tests	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)
Advanced Imaging (MRI/PET/CAT Scans)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$800 per procedure maximum
Inpatient Hospital Services						
Inpatient Hospitalization	10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	30% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day
Outpatient Services						
Outpatient Surgery	10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per day maximum	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per day maximum	30% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per day maximum
Outpatient Lab and Imaging	10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per procedure maximum	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per procedure maximum	30% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$350 per procedure maximum
Emergency Services						
Ambulance Services	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		30% Coinsurance (After Deductible)	
Emergency Room	10% Coinsurance (After Deductible)		20% Coinsurance (After Deductible)		30% Coinsurance (After Deductible)	
Urgent Care						
Urgent Care Visits	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Mental Health and Substance Abuse						
Inpatient Mental Health	10% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	20% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day	30% ⁴ Coinsurance (After Deductible)	50% Coinsurance (After Deductible) ⁴ up to \$1,000 maximum per day

¹When using out-of-network providers, you are responsible for the deductible, coinsurance, and additional amounts exceeding the usual and customary charges.

²The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

³A total of \$250 credits for each member in your family are available to lower your deductible. Please see supplementary plan documents for more information.

⁴\$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).



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Mental Health and Substance Abuse (Continued)						
Outpatient Mental Health Office Visit	\$10 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$20 Copay (Deductible Waived)	50% Coinsurance (After Deductible)	\$30 Copay (Deductible Waived)	50% Coinsurance (After Deductible)
Other Outpatient Mental Health Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)
Other Services						
Acupuncture	10% Coinsurance (After Deductible)	Not Covered	20% Coinsurance (After Deductible)	Not Covered	30% Coinsurance (After Deductible)	Not Covered
Chiropractor Services	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	20% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%	30% Coinsurance (After Deductible)	50% Coinsurance (After Deductible), maximum of 6 visits per calendar year, then plan pays 0%
Hearing Aids	\$500 Maximum Benefit per Ear, Every 12 Months		\$500 Maximum Benefit per Ear, Every 12 Months		\$500 Maximum Benefit per Ear, Every 12 Months	
PRESCRIPTION DRUG BENEFITS						
Annual Prescription Drug Out-of-Pocket Limit						
Individual/Individual in Family/Family	\$2,000/\$2,000/\$4,000 ²	Unlimited	\$2,000/\$2,000/\$4,000 ²	Unlimited	\$2,000/\$2,000/\$4,000 ²	Unlimited
Prescription Drug Deductible						
Per Individual	\$0		\$0		\$0	
Prescription Drug Formulary						
Formulary (Covered Drugs)	National 3-Tier		National 3-Tier		Essential 4-Tier	
Retail						
30-Day Supply						
Generic	\$5 min Copay/ or 20% up to a \$25 Max Copay (Deductible Waived)	Paper claim submission required	\$10 Copay (Deductible Waived)	Paper claim submission required	\$10 Copay (Deductible Waived)	Paper claim submission required
Brand (Formulary/Preferred)			\$20 Copay (Deductible Waived)		\$20 Copay (Deductible Waived)	
Brand (Non-Formulary/Non-Preferred)			\$35 Copay (Deductible Waived)		\$35 Copay (Deductible Waived)	
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	Same as Retail Brand		Same as Retail Brand		20% up to \$150 max copay (Deductible Waived)	
Mail Order						
90-Day Supply						
Generic	\$5 Copay (Deductible Waived)	Paper claim submission required	\$20 Copay (Deductible Waived)	Paper claim submission required	\$20 Copay (Deductible Waived)	Paper claim submission required
Brand (Formulary/Preferred)			\$40 Copay (Deductible Waived)		\$40 Copay (Deductible Waived)	
Brand (Non-Formulary/Non-Preferred)			\$70 Copay (Deductible Waived)		\$70 Copay (Deductible Waived)	
Specialty Rx (Specialty Pharmacy Only; 30-day supply)			\$70 Copay (Deductible Waived)		20% up to \$150 max copay (Deductible Waived)	

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Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the EOC, the EOC will prevail.

