



Deductible PPO Plans

	In Network (You Pay)	Out-of-Network ³ (You Pay)
Option 1	\$300 Self Only / \$600 Family	
Calendar Year Deductible		
Coinsurance (applies to certain services)	20%	40%
Out-of-pocket Maximum (excludes co-pays)	\$800 Self Only / \$1,600 Family	\$1,300 Self Only / \$2,600 Family
Option 2	\$500 Self Only / \$1,000 Family	
Calendar Year Deductible		
Coinsurance (applies to certain services)	20%	40%
Out-of-pocket Maximum (excludes co-pays)	\$1,250 Self Only / \$2,500 Family	\$2,000 Self Only / \$4,000 Family
Option 3	\$1,000 Self Only / \$2,000 Family	
Calendar Year Deductible		
Coinsurance (applies to certain services)	20%	40%
Out-of-pocket Maximum (excludes co-pays)	\$2,000 Self Only / \$4,000 Family	\$3,000 Self Only / \$6,000 Family
Option 4	\$2,500 Self Only / \$5,000 Family	
Calendar Year Deductible		
Coinsurance (applies to certain services)	20%	40%
Out-of-pocket Maximum (excludes co-pays)	\$3,500 Self Only / \$7,000 Family	\$4,500 Self Only / \$9,000 Family
Dependent Children Covered	To Age 25	
Plan Lifetime Maximum	Unlimited	
Preexisting Condition Waiting Period	330 Days (prior coverage credit can reduce or eliminate)	
Physician Office Visit (includes Chiropractic care)	\$30 Copay (for office visit charge)	Deductible and coinsurance
Well Child Care Exams and Immunizations (through age 18)	Nothing	Balance between approved amt. & provider's actual billed charges
Adult Preventive Care		
Adult Routine Physical Exam (1 per year - \$500 limit, including routine lab And X-Ray services) (for colonoscopy see "Outpatient Services")	\$30 copay, plus anything over \$500	Deductible and coinsurance plus anything over \$500
Routine GYN Exam and Pap Smear 2 routine exams per year	Nothing	Deductible and coinsurance
Routine Mammography (1 per year age 40+)	Nothing	Deductible and coinsurance
Routine PSA/DRE Testing (1per year)	Nothing	Deductible and coinsurance
Diagnostic Lab	Nothing	Deductible and coinsurance
Diagnostic X-Ray	Deductible and coinsurance	Deductible and coinsurance
Inpatient Hospital Services¹	Deductible and coinsurance	Deductible and coinsurance
Inpatient Skilled Nursing Services¹	Deductible and coinsurance	Deductible and coinsurance
Outpatient Services	Deductible and coinsurance	Deductible and coinsurance

This is a summary of benefits only and does not replace the legal contract or certificate which identifies all covered services, additional details, limitations and exclusions of the coverage.

¹Pre-certification required. A penalty of \$500 may apply if you fail to obtain pre-certification.

²Benefit limitations for Mental Health and Substance abuse are combined limits.

³When utilizing the services of an out-of-network provider, patient will be responsible for the balance between the approved amount and provider's actual billed charges

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	In Network (You Pay)	Out-of-Network³ (You Pay)
Emergency Room	\$100 Copay, waived if admitted	\$100 Copay, waived if admitted
Urgent Care	\$30 Copay	Deductible and coinsurance
Ambulance (includes air transport)	Deductible and coinsurance	Deductible and coinsurance
Maternity Services Inpatient Care¹ (includes routine nursery charges)	Deductible and coinsurance	Deductible and coinsurance
Physician Care	Deductible and coinsurance	Deductible and coinsurance
Outpatient Chemotherapy	Deductible and coinsurance	Deductible and coinsurance
Outpatient Radiation Therapy	Deductible and coinsurance	Deductible and coinsurance
Outpatient Short-term Therapy Services (Includes physical, speech and occupational therapies)	Deductible and coinsurance	Deductible and coinsurance
Mental Health²- Inpatient¹ (limit 30 days)	Deductible and coinsurance	Deductible and coinsurance
Outpatient (limit 60 visits)	Deductible and coinsurance	Deductible and coinsurance
Substance Abuse²- Inpatient¹ Limit 37 days (7 days detox per admission): 2 admissions per lifetime)	Deductible and coinsurance	Deductible and coinsurance
Outpatient (limit 60 visits)	Deductible and coinsurance	Deductible and coinsurance
Surgical Care Including Office Surgery	Deductible and coinsurance	Deductible and coinsurance
Human Organ and Tissue Transplant Services¹	Deductible and coinsurance	Deductible and coinsurance
Home Health Care (unlimited visits)	Deductible and coinsurance	Deductible and coinsurance
Hospice	Deductible and coinsurance	Deductible and coinsurance
Diabetic Equipment and Supplies Diabetic Supplies	\$30 Copay per supply	Not covered
Diabetic Equipment (includes insulin pumps)	Deductible and coinsurance	Deductible and coinsurance
Durable Medical Equipment	Deductible and coinsurance	Deductible and coinsurance
Prescription Medicines, including oral contraceptives:		
Retail (30 day supply)	Tier 1 - \$10 copay Tier 2 - \$30 copay Tier 3 - \$50 copay	Not covered
Mail Order (90 day supply)	Tier 1 - \$20 copay Tier 2 - \$60 copay Tier 3 - \$100 copay	Not covered
Tier 1 = Generic medications Tier 2 = Preferred brand-name medications Tier 3 = Non-preferred brand-name medications		
24-Hour coverage included!	\$2,000 Accident Policy included!	Vision Care discounts included!

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