

Plan Design Feature	Basic (70/30)		Standard (80/20)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Benefit Year Deductible</b>	<b>\$933</b> Individual <b>\$2,799</b> Family	<b>\$1,866</b> Individual <b>\$5,598</b> Family	<b>\$700</b> Individual <b>\$2,100</b> Family	<b>\$1,400</b> Individual <b>\$4,200</b> Family
<b>Plan Coinsurance</b>	<b>30%</b> of eligible expenses after deductible	<b>50%</b> of eligible expenses after deductible <b>and the difference between the allowed amount and the charge</b>	<b>20%</b> of eligible expenses after deductible	<b>40%</b> of eligible expenses after deductible <b>and the difference between the allowed amount and the charge</b>
<b>Coinsurance Maximum (does not include deductible)</b>	<b>\$3,793</b> Individual <b>\$11,379</b> Family	<b>\$7,586</b> Individual <b>\$22,758</b> Family	<b>\$3,210</b> Individual <b>\$9,630</b> Family	<b>\$6,420</b> Individual <b>\$19,260</b> Family
<b>Office Visits</b>	<b>\$35<sup>1</sup></b> copay primary care <b>\$81<sup>1</sup></b> copay specialist	<b>50%</b> coinsurance after deductible	<b>\$30<sup>1</sup></b> copay primary care <b>\$70<sup>1</sup></b> copay specialist	<b>40%</b> coinsurance after deductible
<b>Urgent Care</b>	<b>\$87</b> copay	Same as in-network benefit	<b>\$87</b> copay	Same as in-network benefit
<b>Emergency Room</b>	<b>\$291</b> copay plus <b>30%</b> coinsurance after deductible	Same as in-network benefit	<b>\$233</b> copay plus <b>20%</b> coinsurance after deductible	Same as in-network benefit
<b>Inpatient</b>	<b>\$291</b> copay plus <b>30%</b> coinsurance after deductible	<b>\$291</b> copay then <b>50%</b> coinsurance after deductible	<b>\$233</b> copay plus <b>20%</b> coinsurance after deductible	<b>\$233</b> copay then <b>40%</b> coinsurance after deductible
<b>Outpatient Hospital and Ambulatory Surgical Center</b>	<b>30%</b> coinsurance after deductible	<b>50%</b> coinsurance after deductible	<b>20%</b> coinsurance after deductible	<b>40%</b> coinsurance after deductible
<b>Preventive Care</b>	<b>\$35<sup>1</sup></b> copay primary care <b>\$81<sup>1</sup></b> copay specialist	Not covered <sup>2</sup>	<b>\$30<sup>1</sup></b> copay primary care <b>\$70<sup>1</sup></b> copay specialist	Not covered <sup>2</sup>
<b>Short-Term Rehabilitative Therapies</b>				
<b>Evaluation and Management</b>	<b>\$35</b> copay primary care <b>\$81</b> copay specialist	<b>50%</b> after deductible <b>50%</b> after deductible	<b>\$30</b> copay primary care <b>\$70</b> copay specialist	<b>40%</b> after deductible <b>40%</b> after deductible
<b>Therapy Services</b>	<b>\$64</b> copay	<b>50%</b> after deductible	<b>\$52</b> copay	<b>40%</b> after deductible
Limited to rehabilitative physical therapy, occupational therapy, and speech therapy (PT/OT/ST)				
<b>Chiropractic (Chiro)</b>	<b>\$64<sup>1</sup></b> copay - 30 visit limit per benefit period	<b>50%</b> coinsurance after deductible	<b>\$52<sup>1</sup></b> copay - 30 visit limit per benefit period	<b>40%</b> coinsurance after deductible
<b>Mental Health/ Substance Abuse (MH/SA)</b>				
<b>Office Services</b>	<b>\$64<sup>1</sup></b> copay	<b>50%</b> coinsurance	<b>\$52<sup>1</sup></b> copay	<b>40%</b> coinsurance
<b>Outpatient Services</b>	<b>30%</b> coinsurance after deductible	<b>50%</b> coinsurance after deductible	<b>20%</b> coinsurance after deductible	<b>40%</b> coinsurance after deductible
<b>Inpatient Services</b>	<b>\$291</b> copay then 30% coinsurance after deductible	<b>\$291</b> copay then 50% coinsurance after deductible	<b>\$233</b> copay then 20% coinsurance after deductible	<b>\$233</b> copay then 40% coinsurance after deductible
	Prior authorization is required after 26-combined in and out-of-network office visits		Prior authorization is required after 26-combined in and out-of-network office visits	
<b>Generic Rx</b>	<b>\$12</b> copay for 30 day supply		<b>\$12</b> copay for 30 day supply	
<b>Preferred Brand Rx (no generic equivalent)</b>	<b>\$40</b> copay for 30 day supply		<b>\$40</b> copay for 30 day supply	
<b>Non-Preferred Brand Rx (no generic equivalent)</b>	<b>\$64</b> copay for 30 day supply		<b>\$64</b> copay for 30 day supply	
For brand name drugs with an available generic, members will be required to pay the generic copay, plus the difference between the Plan's cost of the brand name drug and the Plan's cost of the generic drug, not to exceed \$100 per 30-day supply.				
<b>Specialty Rx<sup>3</sup></b>	<b>25%</b> coinsurance up to <b>\$100</b> for each <b>30</b> day supply		<b>25%</b> coinsurance up to <b>\$100</b> for each <b>30</b> day supply	
<b>Diabetic Supplies<sup>4</sup></b>	<b>\$10</b> copay for preferred brand for <b>30</b> day supply <b>\$25</b> copay for non-preferred brand for <b>30</b> day supply		<b>\$10</b> copay for preferred brand for <b>30</b> day supply <b>\$25</b> copay for non-preferred brand for <b>30</b> day supply	

- In-network hospital owned or operated practices may be subject to deductible and coinsurance. Please call your physician or see the Provider Directory to determine if your physician's practice is hospital owned or operated.
- The following preventive care benefits are available both in and out-of-network: gynecological exams, cervical cancer screenings, ovarian cancer screening, screening mammograms, colorectal screening and prostate specific antigen tests.
- All non-acute specialty drugs, excluding cancer medications, must be obtained through the Accredo specialty pharmacy.
- For a single copay, insulin dependent members will receive 153 test strips and non-insulin dependent members receive 51 test strips per 30 day supply. Additional test strips needed are covered under the medical supply benefit.

All benefits are subject to medical necessity. Amounts shown reflect what the members pay.