

	Basic (70/30)		Standard (80/20)	
Plan Design Feature	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Benefit Year Deductible	\$ 933 Individual \$2,799 Family	\$1,866 Individual \$5,598 Family	\$ 700 Individual \$2,100 Family	\$1,400 Individual \$4,200 Family
Plan Coinsurance	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum (does not include deductible)	\$ 3,793 Individual \$11,379 Family	\$ 7,586 Individual \$22,758 Family	\$3,210 Individual \$9,630 Family	\$ 6,420 Individual \$19,260 Family
Office Visits	\$35 ¹ copay primary care \$81 ¹ copay specialist	50% coinsurance after deductible	\$30 ¹ copay primary care \$70 ¹ copay specialist	40% coinsurance after deductible
Urgent Care	\$87 copay	Same as in-network benefit	\$87 copay	Same as in-network benefit
Emergency Room	\$291 copay plus 30% coinsurance after deductible	Same as in-network benefit	\$233 copay plus 20% coinsurance after deductible	Same as in-network benefit
Inpatient	\$291 copay plus 30% coinsurance after deductible	\$291 copay then 50% coinsurance after deductible	\$233 copay plus 20% coinsurance after deductible	\$233 copay then 40% coinsurance after deductible
Outpatient Hospital and Ambulatory Surgical Center	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Preventive Care	\$35 ¹ copay primary care \$81 ¹ copay specialist	Not covered ²	\$30 ¹ copay primary care \$70 ¹ copay specialist	Not covered ²
Short-Term Rehabilitative Therapies				
Evaluation and Management	\$35 copay primary care \$81 copay specialist	50% after deductible 50% after deductible	\$30 copay primary care \$70 copay specialist	40% after deductible 40% after deductible
Therapy Services	\$64 copay	50% after deductible	\$52 copay	40% after deductible
Limited to rehabilitative physical therapy, occupational therapy, and speech therapy (PT/OT/ST)				
Chiropractic (Chiro)	\$64 ¹ copay - 30 visit limit per benefit period	50% coinsurance after deductible	\$52 ¹ copay - 30 visit limit per benefit period	40% coinsurance after deductible
Mental Health/ Substance Abuse (MH/SA)				
Office Services	\$64 ¹ copay	50% coinsurance	\$52 ¹ copay	40% coinsurance
Outpatient Services	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Inpatient Services	\$291 copay then 30% coinsurance after deductible	\$291 copay then 50% coinsurance after deductible	\$233 copay then 20% coinsurance after deductible	\$233 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	
Generic Rx	\$12 copay for 30 day supply		\$12 copay for 30 day supply	
Preferred Brand Rx (no generic equivalent)	\$40 copay for 30 day supply		\$40 copay for 30 day supply	
Non-Preferred Brand Rx (no generic equivalent)	\$64 copay for 30 day supply		\$64 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.				
Specialty Rx³	25% coinsurance up to \$100 for each 30 day supply		25% coinsurance up to \$100 for each 30 day supply	
Diabetic Supplies⁴	\$10 copay for preferred brand for 30 day supply \$25 copay for non-preferred brand for 30 day supply		\$10 copay for preferred brand for 30 day supply \$25 copay for non-preferred brand for 30 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.