

Benefits at a Glance

Benefit		You Pay
Inpatient Hospital (precertification required)		
Medical/Surgery/Maternity	PPO: 10% of Plan Allowance. No deductible.	Non-PPO: \$100 copayment per admission and 30% of Plan Allowance. No deductible.
Mental Health/Substance Abuse	PPO: Nothing. No deductible.	Non-PPO: \$500 copayment per admission: 50% of Plan Allowance and all charges after 50 days. No deductible.
Outpatient Hospital		
Medical/Surgery/Emergency	PPO: 15% of Plan Allowance. Charges subject to \$250 calendar year deductible.	Non-PPO: 30% of Plan Allowance. Charges subject to \$300 calendar year deductible.
Physician Care		
Surgery/Maternity (Delivery)	PPO: 10% of Plan Allowance. Charges subject to \$250 calendar year deductible.	Non-PPO: 30% of Plan Allowance. Charges subject to \$300 calendar year deductible.
Accidental Injury (Nonsurgical Care)	PPO: Within 72 hours: Nothing. No deductible.	Non-PPO: Within 72 hours: The difference, if any, between our payment and the billed charges. No deductible.
Medical Care, such as office visits, lab, x-ray, diagnostic services	PPO: \$20 copayment per office visit. No deductible. 15% of Plan Allowance for most other services. Charges subject to \$250 calendar year deductible.	Non-PPO: 30% of Plan Allowance for most services. Charges subject to \$300 calendar year deductible.
Mental Health and Substance Abuse Care	PPO: \$20 copayment per office visit. No deductible. 15% of Plan Allowance for other services. Charges subject to separate \$250 calendar year deductible.	Non-PPO: 50% of Plan Allowance. All charges after 30 visits subject to separate \$300 calendar year deductible.
Well Child Care (up to age 3) and Immunizations (up to age 22)	PPO: Nothing. No deductible.	Non-PPO: The difference, if any, between our payment and the billed charges. No deductible.
Prescription Drugs		
Retail Pharmacy (1) You must receive prior authorization for biotech/specialty drugs or benefits will be reduced. (2) This is a mandatory generic program with a 30-day dispensing limit.	Network Pharmacy; 1st or 2nd fill: 25% of cost. No deductible. Network Pharmacy; 3rd (or more) fill: Full cost at time of purchase. You will need to file a claim to receive a 50% reimbursement of the Plan Allowance after a \$25 deductible is met.	Non-Network Pharmacy: Full cost at time of purchase. You will need to file a claim to receive a 50% reimbursement of the Plan Allowance after a \$25 deductible is met.
Mail Order Program	60-day supply: \$8 generic/\$24 brand name 90-day supply: \$12 generic/\$35 brand name No deductible.	
Catastrophic Limits		
Medical/Surgery/Maternity	Nothing after coinsurance expenses total: <ul style="list-style-type: none"> \$4000 per person or family for services of PPO providers/facilities \$6000 per person or family for services of PPO and non-PPO providers/facilities combined. 	
Mental Health and Substance Abuse	Nothing after coinsurance expenses total: <ul style="list-style-type: none"> \$3000 per person or family for services of network mental health and substance abuse providers/facilities \$8000 per person for out-of-network mental health and substance abuse inpatient hospital treatment (to a maximum of 50 days). 	