

	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	\$466 Individual \$1,399 Family	\$933 Individual \$2,799 Family	\$350 Individual \$1,050 Family	\$700 Individual \$2,100 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)	\$1,896 Individual \$5,689 Family	\$3,793 Individual \$11,379 Family	\$1,605 Individual \$4,815 Family	\$3,210 Individual \$9,630 Family
Office Visits	\$35¹ copay primary care \$81¹ copay specialist	50% coinsurance after deductible	\$30¹ copay primary care \$70¹ 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	\$35¹ copay primary care \$81¹ copay specialist	Not covered ²	\$30¹ copay primary care \$70¹ 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)	\$64¹ copay - 30 visit limit per benefit period	50% coinsurance after deductible	\$52¹ copay - 30 visit limit per benefit period	40% coinsurance after deductible
Mental Health/ Substance Abuse (MH/SA)				
Office Services	\$35¹ copay	50% coinsurance	\$30¹ 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	
Tier 1 Rx	\$12 copay for 30 day supply		\$12 copay for 30 day supply	
Tier 2 Rx	\$40 copay for 30 day supply		\$40 copay for 30 day supply	
Tier 3 Rx	\$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 Tier 1 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.				
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	

1. 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.
2. 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.
3. All non-acute specialty drugs, excluding cancer medications, must be obtained through the Accredo specialty pharmacy.
4. For a single copayment, insulin dependent members may receive 200 up to 204 test strips (depending on manufacturer's packaging) and non-insulin dependent members may receive 100 or 102 (depending on manufacturer's packaging) test strips per 30-day supply. Additional test strips are covered under your medical supply benefit and are subject to deductible and coinsurance.

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