General Information

Cost Sharing Expenses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$2,500	$3,000	$6,000	One deductible for both in and out of network combined. Deductible applies to annual OOP Maximum. Integrated Rx applies to deductible and OOP maximum.
Deductible - Family	$5,000	$6,000	$12,000	The family deductible is met for all when one or more people on the contract meet the total family deductible. Family equals 2 or more people. One deductible for both in and out of network combined. Deductible applies to OOP Maximum. Integrated Rx applies to deductible and OOP maximum.
Coinsurance	10%	40%	50%	
Annual Out of Pocket Maximum - Single	$5,000	$9,000	$18,000	Includes deductible, coinsurance and Integrated Rx expenses. Services rendered in any tier accumulate to all three out of pockets limits.
Annual Out of Pocket Maximum - Family	$10,000	$15,800	$36,000	The annual family OOP maximum is met for all when or or more people of the contract meet the annual family OOP maximum. Family equals 2 or more people. Once a person under a Family contract meets the per person cap amount of $6,650 Domestic, the person will no longer pay for covered services and claims will be paid at 100% by the Health Plan for the remainder of the year. The Per Person Cap includes deductible, coinsurance, and copays. The remaining annual family OOP Maximum still needs to be met by any combination of family members on the contract.
Annual Out of Pocket Maximum - Per Person Cap	$6,650	$6,650	$18,000	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.

Office Visit Cost Shares

Benefit Name	Domestic	In Network	Out of Network	
Cost Share - Primary Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	INN Coins for all Services other than PCP and Spec are 40%. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Cost Share - Specialist	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	INN Coins for all Sevices other than PCP and Spec are 40%. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

	Domestic	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year				Calendar Year Benefits
Diabetic Preauthorization and Step Therapy				Yes

Who is Covered

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage				Covered

Inpatient Services

Inpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Mental Health Care	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Substance Use Detoxification	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Skilled Nursing Facility	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	120 Days Per Plan Year Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network. 360 Days Lifetime Max. Limits are combined Domestic, INN and OON.
Physical Rehabilitation	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	60 Days per year Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network. Limits are combined Domestic, INN and OON.
Maternity Care	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Inpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Anesthesia	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Diagnostic X-ray	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Diagnostic Laboratory and Pathology	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Radiation Therapy	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Chemotherapy	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Mental Health Care	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Includes Partial Hospitalization. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Substance Use Care	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Includes Partial Hospitalization. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Home and Hospice Care

Home Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Home Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Home Infusion Therapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Hospice Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Outpatient and Office Professional Services

Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Diagnostic X-ray	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Diagnostic Laboratory and Pathology	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Radiation Therapy	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Chemotherapy	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Mental Health Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Maternity Care	PCP/Specialist - Covered in Full Subject to Deductible	PCP/Specialist - Covered in Full Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full, subject to the deductible, for In-Network.
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Chiropractic Care	PCP/Specialist - Not Available	PCP/Specialist - 10% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	30 Visits per Year Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Allergy Testing	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Allergy Treatment Including Serum	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums). Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Hearing Evaluations Routine	PCP/Specialist - Not Available	PCP/Specialist - 10% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	1 Exam every 2 years Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Rehab and Habilitation

Outpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	30 Visits Per Plan Year Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Occupational Rehabilitation	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	30 Visits per year Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Speech Rehabilitation	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	30 Visits per year Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Outpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	30 Visits per year Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Occupational Rehabilitation	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	30 Visits per year Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Speech Rehabilitation	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	30 Visits per year Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	1 Exam Per Plan Year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	50% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	50% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Bone Density Screening Professional	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Colonoscopy Screening Facility	Covered in Full	Covered in Full	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Bone Density Screening Facility	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Other Benefits

Additional Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Diabetic Equipment	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Durable Medical Equipment (DME)	PCP/Specialist - Not Available	PCP/Specialist - 10% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Medical Supplies	PCP/Specialist - Not Available	PCP/Specialist - 10% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Acupuncture	PCP/Specialist - Not Available	PCP/Specialist - 10% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	10 Visits per year Limits are combined Domestic, INN and OON. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.
Private Duty Nursing	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Transportation

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Not Available	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	

Urgent Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): 10% Coinsurance, subject to the deductible, for In-Network.

Ancillary Benefits

Vision

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Adult Eye Exams - Routine	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	50% Coinsurance Subject to Deductible	1 Exam every 2 years Limits are combined Domestic, INN and OON. One pair of corrective lenses after cataract surgery covered in full.
Adult Eyewear - Routine	Covered	Covered	50% Coinsurance Subject to Deductible	$60 Reimbursement every 2 years Includes Frames/Lenses or Contact Lenses
Pediatric Eye Exams - Routine	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	50% Coinsurance Subject to Deductible	1 Exam Per Plan Year Limits are combined Domestic, INN and OON. One pair of corrective lenses after cataract surgery covered in full.
Pediatric Eyewear - Routine	Covered	Covered	50% Coinsurance Subject to Deductible	$60 Reimbursement Per Plan Year Includes Frames/Lenses or Contact Lenses

Rx Benefits

Rx Plan

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Rx Plan				$10/$30/$50 Subj. to Ded. Dom. $25/$50/$90 Subj. to Ded, No Ded Prev Rx

Rx Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	90	90		
Days Supply Per Mail Order	Not Available	90		
Copays Per Mail Order Supply	3	3		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.