

Benefit	PPO Plans IIP: 10022, 10023, 10024, 10025			
	In-Network		Out-of-Network	
Annual Calendar Year Deductible (Deductible must be met before payments are made - includes pharmacy)	Individual	Family	Individual	Family
	10022 \$1,200	\$2,400	10022 \$2,500	\$5,000
	10023 \$2,500 ³	\$5,000 ³	10023 \$5,000	\$10,000
	10024 \$2,500	\$5,000	10024 \$5,000	\$10,000
	10025 \$5,000 ³	\$10,000 ³	10025 \$10,000	\$20,000
Annual Out-of-Pocket Maximum (Includes Deductible)	Individual	Family	Individual	Family
	10022 \$2,400	\$5,000	10022 \$5,000	\$10,000
	10023 \$2,500 ³	\$5,000 ³	10023 \$10,000	\$20,000
	10024 \$4,000	\$8,000	10024 \$8,000	\$16,000
	10025 \$5,000 ³	\$10,000 ³	10025 \$20,000	\$40,000
Lifetime Maximum	\$5 million combined in and out-of-network			
Maximum Lifetime Hospice Benefit	\$7,500 combined in and out-of-network			
Pre-Existing Limitation (Does not apply to pregnancy, newborns and newly adopted children)	<ul style="list-style-type: none"> ▪ No Pre-existing limitation if prior Creditable Coverage ▪ New Hires: 6/6 ▪ Late Enrollees: 6/18 			
Physician Services				
Non-Specialist office visits	20%		40%	
Specialist office visits	20%		40%	
Outpatient Surgery (In Physician's office)	20%		40%	
Specialty Pharmaceuticals ¹ (Injectable forms administered in Physician's office)	15% up to a max. of \$250 per injection		15% up to a max. of \$250 per injection	
Allergy Services				
Testing	20%		40%	
Serum (extracts)	20%		40%	
Injections	20%		40%	
Clinical Preventive Services ² - such as but not limited to:				
Routine Physicals	Plan pays 100%			
Adult Immunizations	If the Optional Benefit Drug Rider is purchased, prescription drugs are not included in Clinical Preventive Services and are therefore subject to the Deductible and applicable Co-insurance.		40%	
Child Immunizations				
Well Child Care				
Routine Mammography/Pap Smear				
Women's Health Care				
Gynecological Care	20%		40%	
In office Obstetrical/Maternity Care	20%		40%	
Delivery ¹	20%		40%	
Diabetes Services				
Diabetes Education and Office Visits	20%		40%	

¹ Benefit Certification may be required. ² Not subject to Deductible ³ The Plan pays 100% of all covered charges for In-Network Services, after the Deductible is met. Member is still responsible for Out-of-Network Deductible/Co-insurance and charges above Reasonable and Customary. This summary of Covered Benefits and services is subject to the provisions of the Group Subscriber Agreement and cannot modify or affect the Group Subscriber Agreement in any way, nor shall you accrue any rights because of any statement in or omission from this summary.

Benefit	PPO Plans IIP: 10022, 10023, 10024, 10025	
	In-Network	Out-of-Network
Hospital Outpatient Services		
Surgeries ¹	20%	40%
Diagnostic Tests: Lab and X-Ray ¹	20%	40%
Hospital Inpatient Services ¹		
Room & Board	20%	40%
Inpatient Physician Care	20%	40%
Hospice Care ¹	20%	40%
Accidental Injury/Urgent/ Emergency Care		
Emergency Care including trauma	20%	20% Initial treatment only, 40% follow-up care
Urgent Care	20%	20% Initial treatment only, 40% follow-up care
Ambulance Services	20%	40%
Complementary Therapies		
Acupuncture (\$1,500/Calendar Year maximum)	20%	Not Covered
Chiropractic (\$1,500/Calendar Year maximum)	20%	Not Covered
Mental Health Services ¹		
Outpatient	20%	40%
Inpatient/Partial Hospitalization	20%	40%
Rehabilitation Services		
Cardiac and Pulmonary Rehabilitation	20%	40%
Occupational, physical and speech therapy ¹ (up to 2 months per condition per Calendar Year)	20%	40%
Durable Medical Equipment, Prosthetics, Appliances ¹	20%	40% (\$1,000/Calendar Year maximum)
Transplants ¹	20%	Not Covered
Prescription Drugs	Optional Benefit Drug Rider	
Generic (Preferred)	20%	Not Covered (must use Participating Pharmacy)
Brand (Preferred)	20%	
Brand when generic is available	Generic plus the cost difference	
Non-Preferred	30%	
Diabetic Supplies Brand/Generic/Non-Preferred	20% / 20% / 30%	
Prepackaged Items Brand/Generic/Non-Preferred	20% / 20% / 30%	
Specialty Pharmaceuticals ¹	15% up to \$250 per prescription	
Alcoholism/Substance Abuse ¹	Optional Benefit Substance Abuse Rider	
Inpatient or Partial Hospitalization (up to 30 days per Calendar Year)	20%	40%
Outpatient (up to 30 visits per Calendar Year)	20%	40%

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