Refer to the Plan Document and Summary Plan Description for details of Coverage.

BASE PLAN BENEFITS	PPO PROVIDERS	NON-PPO PROVIDERS
Calendar Year Deductible	$2,500 per individual $7,500 per family (accumulative)	$5,000 per individual $15,000 per family (accumulative)
	Calendar Year deductible does not include Medical Plan Co-payments, Prescription Drug Co-payments or non-covered expenses. Charges applied to the Non-PPO Calendar Year deductible shall also apply to the PPO Calendar Year Deductible. However, charges applied to the PPO Calendar Year deductible SHALL NOT apply to the Non-PPO Calendar Year deductible.	
Coinsurance	80% of covered expenses after the Calendar Year deductible is satisfied.	70% of covered expenses after the Calendar Year deductible is satisfied.
Out-of-Pocket Maximum	$6,500 per individual $19,500 per family (accumulative)	Unlimited.
	The Out-of-Pocket Maximum shall include the Calendar Year Deductible, Medical Plan Co-payments and Prescription Drug Co-payments. Non-covered expenses and charges in excess of Reasonable & Customary charges DO NOT apply toward the Out-of-Pocket Maximum. Charges applied to the Non-PPO Out-of-Pocket Maximum shall also apply to the PPO Out-of-Pocket Maximum. However, charges applied to the PPO Out-of-Pocket Maximum SHALL NOT apply to the Non-PPO Out-of-Pocket maximum.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment	**Inpatient Hospitalization:** 80% Coinsurance; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses; not subject to Calendar Year deductible.	**Inpatient Hospitalization:** 70% Coinsurance; subject to Calendar Year deductible. **Outpatient Services:** 70% Coinsurance; subject to Calendar Year deductible.
Ambulance Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Birthing Center	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Colonoscopy Services	**Preventive / Routine Outpatient Colonoscopy:** 100% of eligible charges following a $50 Co-payment. **Diagnostic Outpatient Colonoscopy:** 80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Durable Medical Equipment	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Emergency Room Services	100% of covered expenses following a $150 Co-payment per visit. Emergency Room Co-payment will be waived if the patient is admitted into the hospital from the emergency room.	
Extended Care Facility Calendar Year maximum benefit of 60 days.	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	(Includes Rehabilitation Facility & Skilled Nursing Facility)	
Home Health Care	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Hospice Care Includes Bereavement Counseling	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Infertility Services Lifetime maximum benefit of $5,000 Primary Care Provider (PCP) includes: Internal Medicine, Family Practice, Pediatrics & OB/Gynecology	**Primary Care Provider Office Visit:** 100% of eligible charges following a $25 Co-payment. **Specialist Office Visit:** 100% of eligible charges following a $50 Co-payment. **Inpatient/Outpatient Hospital and related Professional services:** 80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services Includes Physician Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

BASE PLAN BENEFITS	PPO PROVIDERS	NON-PPO PROVIDERS
Maternity Care (Dependent daughters covered for complications only)	Initial diagnosis and office visit is payable at 100% following a $25 Co-payment; Physician obstetrical fee for all pre-natal care and delivery shall be payable at 80% subject to the Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Refer to Inpatient Hospital Services for benefits payable in connection with delivery in a Hospital.	
Mental Health Services	**Inpatient Hospitalization:** 80% Coinsurance; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses; not subject to Calendar Year deductible.	**Inpatient Hospitalization:** 70% Coinsurance; subject to Calendar Year deductible. **Outpatient Services:** 70% Coinsurance; subject to Calendar Year deductible.
Outpatient Physician Office Visit Services Primary Care Provider (PCP) includes: Internal Medicine, Family Practice, Pediatrics & OB/Gynecology A Co-payment will not apply if the Patient receives services such as allergy shots or other injections and is not charged for an Office Visit by the Physician.	**Primary Care Provider Office Visit:** 100% of eligible charges following a $25 Co-payment. **Specialist Office Visit:** 100% of eligible charges following a $50 Co-payment.	70% Coinsurance; subject to Calendar Year deductible.
	Includes office visit charges, standard x-ray, laboratory, diagnostic services, supplies & minor surgical procedures performed in the Physician's office during the office visit. **Refer to Outpatient X-Ray & Laboratory Services benefit for treatment rendered outside of the Physicians office and for CT scans, MRI's, MRA's and PET scans in any location, including the Physician's office.**	
Outpatient Private Duty Nursing	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Outpatient Surgery Ambulatory Surgical Center or Outpatient Surgery in a Hospital	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Outpatient X-Ray, Laboratory & Diagnostic Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Includes CT scans, MRI's, MRA's and PET scans in any location, including the Physician's office.	
Pre-Certification Requirements	Pre-admission certification for an elective non-emergency hospital admission is mandatory. Emergency admissions must be approved within 48 hours. Failure to comply will result in a denial of benefits due to pre-certification non-compliance.	
Prescription Drug Benefits Retail Prescriptions (30 day supply maximum) Mail Order Prescriptions (90 day supply maximum) Infertility Drugs are subject to a $5,000 lifetime maximum benefit.	**Retail Network Pharmacy:** ▪ Tier 1 - Generic drugs: $10 Co-payment ▪ Tier 2 - Preferred Brand drugs: $35 Co-payment ▪ Tier 3 - Brand name drugs: $50 Co-payment **Mail Order Prescriptions:** ▪ Tier 1 - Generic drugs: $10 Co-payment ▪ Tier 2 - Preferred Brand drugs: $35 Co-payment ▪ Tier 3 - Brand name drugs: $50 Co-payment **Specialty Pharmacy Program** (for certain high-cost drugs) 75% of covered expenses; not subject to Calendar Year deductible.	Applicable Co-payment + charge over Network allowable amount.
Prosthetics / Orthotics	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Routine Well Adult Care (Age 17 and above) *Annual hearing examination is for an annual examination only and does not include hearing aids or other related hardware.	100% of eligible charges; not subject to the Calendar Year deductible.	Benefits are not available when a Non-PPO Provider is utilized unless services are for a Pap test, Mammogram or PSA screening.
	This routine benefit includes physician charges and related laboratory charges for annual routine preventive examinations and the preventive services outlined below: ▪ Immunizations. ▪ Annual hearing examination.* ▪ Fasting lipoprotein profile (cholesterol screening). ▪ Annual Prostate Specific Antigen (PSA) screening. ▪ Fasting blood sugar screening (for diabetes mellitus). ▪ Blood pressure screening. ▪ Annual colorectal screening. ▪ Annual mammogram screening. ▪ Annual pelvic exam and Pap test. ▪ EKG. ▪ Bone Mineral Density (BMD) screening (once every 24 months).	
Routine Well Child Care (Birth through age 16)	100% of eligible charges; not subject to the Calendar Year deductible.	Benefits are not available when a Non-PPO Provider is utilized.
	Includes Office Visit charges, immunizations, laboratory blood tests & routine vision & hearing screenings.	

BASE PLAN BENEFITS	PPO PROVIDERS	NON-PPO PROVIDERS
Therapy Services Maximum benefit of 30 visits per type of Therapy, per Calendar Year. Primary Care Provider (PCP) includes: Internal Medicine, Family Practice, Pediatrics & OB/Gynecology	**Primary Care Provider Services:** 100% of eligible charges following a $25 Co-payment. **Specialist Services:** 100% of eligible charges following a $50 Co-payment.	70% Coinsurance; subject to Calendar Year deductible.
	Benefits shall be payable for Spinal Manipulation, Physical Therapy, Speech Therapy and Occupational Therapy.	
Transplant Benefit	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Urgent Care Center Services	100% of covered expenses following a $50 Co-payment per visit. Refer to Emergency Room Services benefit for services rendered in the Emergency room department of a hospital.	
Vision Care Annual Comprehensive Eye Exam (Diagnostic)	100% of eligible charges following a $50 Co-payment.	Benefits are not available when a Non-PPO Provider is utilized.
	Annual vision examination does not include glasses, contact lenses or other related hardware.	
All Other Covered Medical Expenses	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

Out-of-Area Benefits are available through the Plan and shall be payable at the PPO Provider level.

Questions regarding Coverage and/or Benefits should be directed to:

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