Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

RBRVS						
	PPO 0/90/70 ($10) PLAN CODE 3S4		PPO 0/90/70 ($15) PLAN CODE 3R6		PPO 0/90/70 ($20) PLAN CODE 3R7	
Key Benefits	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$0	$250	$0	$250	$0	$250
Family =	$0	$750	$0	$750	$0	$750
Coinsurance	10%	30%	10%	30%	10%	30%
Maximum out-of-pocket costs						
Individual =	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Family =	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	30%	$15	30%	$20	30%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	30%	$15	30%	$20	30%
X-ray and Laboratory procedures	10%	30%	10%	30%	10%	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	10%	30% ($600 max allow per day)	10%	30% ($600 max allow per day)	10%	30% ($600 max allow per day)
Outpatient Services	10%	30%	10%	30%	10%	30%
Outpatient Surgery	10%	30% ($350 max payable per day)	10%	30% ($350 max payable per day)	10%	30% ($350 max payable per day)
Skilled Nursing Facility	10%	30% ($250 max allow per day)	10%	30% ($250 max allow per day)	10%	30% ($250 max allow per day)
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
Urgent Care (deductible waived if admitted)	$10	30%	$15	30%	$20	30%
Ambulance Services (ground and air)	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/10%	30%/30% ($600 max allow per day)	$15/10%	30%/30% ($600 max allow per day)	$20/10%	30%/30% ($600 max allow per day)
Non-severe mental health (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Acute care detoxification	10% ($250 max allow per day)	30% ($250 max allow per day)	10% ($250 max allow per day)	30% ($250 max allow per day)	10% ($250 max allow per day)	30% ($250 max allow per day)
Other Services						
Durable Medical Equipment	10%	30%	10%	30%	10%	30%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	10%	30%	10%	30%	10%	30%
Chiropractic care	$10	30% ($25 max payable per visit)	$15	30% ($25 max payable per visit)	$20	30% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on limited fee schedule. Limited fee schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of allowed amount in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

C & R						
	PPO 0/90/70 ($10) PLAN CODE 3Q4		PPO 0/90/70 ($15) PLAN CODE 3P6		PPO 0/90/70 ($20) PLAN CODE 3P7	
Key Benefits	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$0	$250	$0	$250	$0	$250
Family =	$0	$750	$0	$750	$0	$750
Coinsurance	10%	30%	10%	30%	10%	30%
Maximum out-of-pocket costs						
Individual =	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Family =	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	30%	$15	30%	$20	30%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	30%	$15	30%	$20	30%
X-ray and Laboratory procedures	10%	30%	10%	30%	10%	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	10%	30%	10%	30%	10%	30%
Outpatient Services	10%	30%	10%	30%	10%	30%
Outpatient Surgery	10%	30%	10%	30%	10%	30%
Skilled Nursing Facility	10%	30%	10%	30%	10%	30%
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
Urgent Care (deductible waived if admitted)	$10	30%	$15	30%	$20	30%
Ambulance Services (ground and air)	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/10%	30%/30%	$15/10%	30%/30%	$20/10%	30%/30%
Non-severe mental health (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Acute care detoxification	10%	30%	10%	30%	10%	30%
Other Services						
Durable Medical Equipment	10%	30%	10%	30%	10%	30%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	10%	30%	10%	30%	10%	30%
Chiropractic care	$10	30% ($25 max payable per visit)	$15	30% ($25 max payable per visit)	$20	30% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary and reasonable in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

RBRVS						
	PPO 0/80/60 ($10) PLAN CODE 3Q6		PPO 0/80/60 ($15) PLAN CODE 3Q7		PPO 0/80/60 ($20) PLAN CODE 3Q8	
Key Benefits	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$0	$250	$0	$250	$0	$250
Family =	$0	$750	$0	$750	$0	$750
Coinsurance	20%	40%	20%	40%	20%	40%
Maximum out-of-pocket costs						
Individual =	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Family =	$9,000	$18,000	$9,000	$18,000	$9,000	$18,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	40%	$15	40%	$20	40%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	40%	$15	40%	$20	40%
X-ray and Laboratory procedures	20%	40%	20%	40%	20%	40%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	20%	40% ($600 max allow per day)	20%	40% ($600 max allow per day)	20%	40% ($600 max allow per day)
Outpatient Services	20%	40%	20%	40%	20%	40%
Outpatient Surgery	20%	40% ($350 max payable per day)	20%	40% ($350 max payable per day)	20%	40% ($350 max payable per day)
Skilled Nursing Facility	20%	40% ($250 max allow per day)	20%	40% ($250 max allow per day)	20%	40% ($250 max allow per day)
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 20%	$100 + 40%	$100 + 40%
Urgent Care (deductible waived if admitted)	$10	40%	$15	40%	$20	40%
Ambulance Services (ground and air)	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/20%	40%/40% ($600 max allow per day)	$15/20%	40%/40% ($600 max allow per day)	$20/20%	40%/40% ($600 max allow per day)
Non-severe mental health (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Acute care detoxification	20% ($250 max allow per day)	40% ($250 max allow per day)	20% ($250 max allow per day)	40% ($250 max allow per day)	20% ($250 max allow per day)	40% ($250 max allow per day)
Other Services						
Durable Medical Equipment	20%	40%	20%	40%	20%	40%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	20%	40%	20%	40%	20%	40%
Chiropractic care	$10	40% ($25 max payable per visit)	$15	40% ($25 max payable per visit)	$20	40% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on limited fee schedule. Limited fee schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of allowed amount in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

C & R						
	PPO 0/80/60 ($10) PLAN CODE 3O7		PPO 0/80/60 ($15) PLAN CODE 3O6		PPO 0/80/60 ($20) PLAN CODE 3O5	
Key Benefits	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$0	$250	$0	$250	$0	$250
Family =	$0	$750	$0	$750	$0	$750
Coinsurance	20%	40%	20%	40%	20%	40%
Maximum out-of-pocket costs						
Individual =	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Family =	$9,000	$18,000	$9,000	$18,000	$9,000	$18,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	40%	$15	40%	$20	40%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	40%	$15	40%	$20	40%
X-ray and Laboratory procedures	20%	40%	20%	40%	20%	40%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	20%	40%	20%	40%	20%	40%
Outpatient Services	20%	40%	20%	40%	20%	40%
Outpatient Surgery	20%	40%	20%	40%	20%	40%
Skilled Nursing Facility	20%	40%	20%	40%	20%	40%
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%
Urgent Care (deductible waived if admitted)	$10	40%	$15	40%	$20	40%
Ambulance Services (ground and air)	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/20%	40%/40%	$15/20%	40%/40%	$20/20%	40%/40%
Non-severe mental health (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Acute care detoxification	20%	40%	20%	40%	20%	40%
Other Services						
Durable Medical Equipment	20%	40%	20%	40%	20%	40%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	20%	40%	20%	40%	20%	40%
Chiropractic care	$10	40% ($25 max payable per visit)	$15	40% ($25 max payable per visit)	$20	40% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary and reasonable in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

RBRVS						
	PPO 250/90/70 ($10) PLAN CODE 3R8		PPO 250/90/70 ($15) PLAN CODE 3R9		PPO 250/90/70 ($20) PLAN CODE 3S1	
Key Benefits	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$250 (in and out-of-network combined)		$250 (in and out-of-network combined)		$250 (in and out-of-network combined)	
Family =	$750 (in and out-of-network combined)		$750 (in and out-of-network combined)		$750 (in and out-of-network combined)	
Coinsurance	10%	30%	10%	30%	10%	30%
Maximum out-of-pocket costs						
Individual =	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Family =	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	30%	$15	30%	$20	30%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	30%	$15	30%	$20	30%
X-ray and Laboratory procedures	10%	30%	10%	30%	10%	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	10%	30% ($600 max allow per day)	10%	30% ($600 max allow per day)	10%	30% ($600 max allow per day)
Outpatient Services	10%	30%	10%	30%	10%	30%
Outpatient Surgery	10%	30% ($350 max payable per day)	10%	30% ($350 max payable per day)	10%	30% ($350 max payable per day)
Skilled Nursing Facility	10%	30% ($250 max allow per day)	10%	30% ($250 max allow per day)	10%	30% ($250 max allow per day)
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
Urgent Care (deductible waived if admitted)	$10	30%	$15	30%	$20	30%
Ambulance Services (ground and air)	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/10%	30%/30% ($600 max allow per day)	$15/10%	30%/30% ($600 max allow per day)	$20/10%	30%/30% ($600 max allow per day)
Non-severe mental health (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Acute care detoxification	10% ($250 max allow per day)	30% ($250 max allow per day)	10% ($250 max allow per day)	30% ($250 max allow per day)	10% ($250 max allow per day)	30% ($250 max allow per day)
Other Services						
Durable Medical Equipment	10%	30%	10%	30%	10%	30%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	10%	30%	10%	30%	10%	30%
Chiropractic care	$10	30% ($25 max payable per visit)	$15	30% ($25 max payable per visit)	$20	30% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on limited fee schedule. Limited fee schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of allowed amount in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

C & R						
	PPO 250/90/70 ($10) PLAN CODE 3P8		PPO 250/90/70 ($15) PLAN CODE 3P9		PPO 250/90/70 ($20) PLAN CODE 3Q1	
Key Benefits	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$250 (in and out-of-network combined)		$250 (in and out-of-network combined)		$250 (in and out-of-network combined)	
Family =	$750 (in and out-of-network combined)		$750 (in and out-of-network combined)		$750 (in and out-of-network combined)	
Coinsurance	10%	30%	10%	30%	10%	30%
Maximum out-of-pocket costs						
Individual =	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Family =	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	30%	$15	30%	$20	30%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	30%	$15	30%	$20	30%
X-ray and Laboratory procedures	10%	30%	10%	30%	10%	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	10%	30%	10%	30%	10%	30%
Outpatient Services	10%	30%	10%	30%	10%	30%
Outpatient Surgery	10%	30%	10%	30%	10%	30%
Skilled Nursing Facility	10%	30%	10%	30%	10%	30%
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
Urgent Care (deductible waived if admitted)	$10	30%	$15	30%	$20	30%
Ambulance Services (ground and air)	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/10%	30%/30%	$15/10%	30%/30%	$20/10%	30%/30%
Non-severe mental health (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Acute care detoxification	10%	30%	10%	30%	10%	30%
Other Services						
Durable Medical Equipment	10%	30%	10%	30%	10%	30%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	10%	30%	10%	30%	10%	30%
Chiropractic care	$10	30% ($25 max payable per visit)	$15	30% ($25 max payable per visit)	$20	30% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary and reasonable in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

RBRVS						
	PPO 250/80/60 ($10) PLAN CODE 3Q9		PPO 250/80/60 ($15) PLAN CODE 3R1		PPO 250/80/60 ($20) PLAN CODE 3R2	
Key Benefits	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$250 (in and out-of-network combined)		$250 (in and out-of-network combined)		$250 (in and out-of-network combined)	
Family =	$750 (in and out-of-network combined)		$750 (in and out-of-network combined)		$750 (in and out-of-network combined)	
Coinsurance	20%	40%	20%	40%	20%	40%
Maximum out-of-pocket costs						
Individual =	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Family =	$9,000	$18,000	$9,000	$18,000	$9,000	$18,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	40%	$15	40%	$20	40%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	40%	$15	40%	$20	40%
X-ray and Laboratory procedures	20%	40%	20%	40%	20%	40%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	20%	40% ($600 max allow per day)	20%	40% ($600 max allow per day)	20%	40% ($600 max allow per day)
Outpatient Services	20%	40%	20%	40%	20%	40%
Outpatient Surgery	20%	40% ($350 max payable per day)	20%	40% ($350 max payable per day)	20%	40% ($350 max payable per day)
Skilled Nursing Facility	20%	40% ($250 max allow per day)	20%	40% ($250 max allow per day)	20%	40% ($250 max allow per day)
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%
Urgent Care (deductible waived if admitted)	$10	40%	$15	40%	$20	40%
Ambulance Services (ground and air)	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/20%	40%/40%($600 max allow per day)	$15/20%	40%/40% ($600 max allow per day)	$20/20%	40%/40%($600 max allow per day)
Non-severe mental health (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40/40%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40/40%
Acute care detoxification	20% ($250 max allow per day)	40% ($250 max allow per day)	20% ($250 max allow per day)	40% ($250 max allow per day)	20% ($250 max allow per day)	40% ($250 max allow per day)
Other Services						
Durable Medical Equipment	20%	40%	20%	40%	20%	40%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	20%	40%	20%	40%	20%	40%
Chiropractic care	$10	40% ($25 max payable per visit)	$15	40% ($25 max payable per visit)	$20	40% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on limited fee schedule. Limited fee schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of allowed amount in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

C & R						
	PPO 250/80/60 ($10) PLAN CODE 3P1		PPO 250/80/60 ($15) PLAN CODE 3O9		PPO 250/80/60 ($20) PLAN CODE 3O8	
Key Benefits	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$250 (in and out-of-network combined)		$250 (in and out-of-network combined)		$250 (in and out-of-network combined)	
Family =	$750 (in and out-of-network combined)		$750 (in and out-of-network combined)		$750 (in and out-of-network combined)	
Coinsurance	20%	40%	20%	40%	20%	40%
Maximum out-of-pocket costs						
Individual =	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Family =	$9,000	$18,000	$9,000	$18,000	$9,000	$18,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	40%	$15	40%	$20	40%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	40%	$15	40%	$20	40%
X-ray and Laboratory procedures	20%	40%	20%	40%	20%	40%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	20%	40%	20%	40%	20%	40%
Outpatient Services	20%	40%	20%	40%	20%	40%
Outpatient Surgery	20%	40%	20%	40%	20%	40%
Skilled Nursing Facility	20%	40%	20%	40%	20%	40%
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%
Urgent Care (deductible waived if admitted)	$10	40%	$15	40%	$20	40%
Ambulance Services (ground and air)	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/20%	40%/40%	$15/20%	40%/40%	$20/20%	40%/40%
Non-severe mental health (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Acute care detoxification	20%	40%	20%	40%	20%	40%
Other Services						
Durable Medical Equipment	20%	40%	20%	40%	20%	40%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	20%	40%	20%	40%	20%	40%
Chiropractic care	$10	40% ($25 max payable per visit)	$15	40% ($25 max payable per visit)	$20	40% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary and reasonable in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

RBRVS						
	PPO 500/90/70 ($10) PLAN CODE 3S2		PPO 500/90/70 ($15) PLAN CODE 3S3		PPO 500/90/70 ($20) PLAN CODE 3R5	
Key Benefits	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$500 (in and out-of-network combined)		$500 (in and out-of-network combined)		$500 (in and out-of-network combined)	
Family =	$1500 (in and out-of-network combined)		$1500 (in and out-of-network combined)		$1500 (in and out-of-network combined)	
Coinsurance	10%	30%	10%	30%	10%	30%
Maximum out-of-pocket costs						
Individual =	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Family =	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	30%	$15	30%	$20	30%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	30%	$15	30%	$20	30%
X-ray and Laboratory procedures	10%	30%	10%	30%	10%	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	10%	30% ($600 max allow per day)	10%	30% ($600 max allow per day)	10%	30% ($600 max allow per day)
Outpatient Services	10%	30%	10%	30%	10%	30%
Outpatient Surgery	10%	30% ($350 max payable per day)	10%	30% ($350 max payable per day)	10%	30% ($350 max payable per day)
Skilled Nursing Facility	10%	30% ($250 max allow per day)	10%	30% ($250 max allow per day)	10%	30% ($250 max allow per day)
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
Urgent Care (deductible waived if admitted)	$10	30%	$15	30%	$20	30%
Ambulance Services (ground and air)	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/10%	30%/30%($600 max allow per day)	$15/10%	30%/30%($600 max allow per day)	$20/10%	30%/30%($600 max allow per day)
Non-severe mental health (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Acute care detoxification	10% ($250 max allow per day)	30% ($250 max allow per day)	10% ($250 max allow per day)	30% ($250 max allow per day)	10% ($250 max allow per day)	30% ($250 max allow per day)
Other Services						
Durable Medical Equipment	10%	30%	10%	30%	10%	30%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	10%	30%	10%	30%	10%	30%
Chiropractic care	$10	30% ($25 max payable per visit)	$15	30% ($25 max payable per visit)	$20	30% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on limited fee schedule. Limited fee schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of allowed amount in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

C & R						
	PPO 500/90/70 ($10) PLAN CODE 3Q2		PPO 500/90/70 ($15) PLAN CODE 3Q3		PPO 500/90/70 ($20) PLAN CODE 3P5	
Key Benefits	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$500 (in and out-of-network combined)		$500 (in and out-of-network combined)		$500 (in and out-of-network combined)	
Family =	$1500 (in and out-of-network combined)		$1500 (in and out-of-network combined)		$1500 (in and out-of-network combined)	
Coinsurance	10%	30%	10%	30%	10%	30%
Maximum out-of-pocket costs						
Individual =	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Family =	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	30%	$15	30%	$20	30%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	30%	$15	30%	$20	30%
X-ray and Laboratory procedures	10%	30%	10%	30%	10%	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	10%	30%	10%	30%	10%	30%
Outpatient Services	10%	30%	10%	30%	10%	30%
Outpatient Surgery	10%	30%	10%	30%	10%	30%
Skilled Nursing Facility	10%	30%	10%	30%	10%	30%
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
Urgent Care (deductible waived if admitted)	$10	30%	$15	30%	$20	30%
Ambulance Services (ground and air)	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/10%	30%/30%	$15/10%	30%/30%	$20/10%	30%/30%
Non-severe mental health (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	10%/10%	30%/30%	10%/10%	30%/30%	10%/10%	30%/30%
Acute care detoxification	10%	30%	10%	30%	10%	30%
Other Services						
Durable Medical Equipment	10%	30%	10%	30%	10%	30%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	10%	30%	10%	30%	10%	30%
Chiropractic care	$10	30% ($25 max payable per visit)	$15	30% ($25 max payable per visit)	$20	30% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary and reasonable in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

RBRVS						
	PPO 500/80/60 ($10) PLAN CODE 3R4		PPO 500/80/60 ($15) PLAN CODE 3R3		PPO 500/80/60 ($20) PLAN CODE 3Q5	
Key Benefits	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$500 (in and out-of-network combined)		$500 (in and out-of-network combined)		$500 (in and out-of-network combined)	
Family =	$1500 (in and out-of-network combined)		$1500 (in and out-of-network combined)		$1500 (in and out-of-network combined)	
Coinsurance	20%	40%	20%	40%	20%	40%
Maximum out-of-pocket costs						
Individual =	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Family =	$9,000	$18,000	$9,000	$18,000	$9,000	$18,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	40%	$15	40%	$20	40%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	40%	$15	40%	$20	40%
X-ray and Laboratory procedures	20%	40%	20%	40%	20%	40%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	20%	40% ($600 max allow per day)	20%	40% ($600 max allow per day)	20%	40% ($600 max allow per day)
Outpatient Services	20%	40%	20%	40%	20%	40%
Outpatient Surgery	20%	40% ($350 max payable per day)	20%	40% ($350 max payable per day)	20%	40% ($350 max payable per day)
Skilled Nursing Facility	20%	40% ($250 max allow per day)	20%	40% ($250 max allow per day)	20%	40% ($250 max allow per day)
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%
Urgent Care (deductible waived if admitted)	$10	40%	$15	40%	$20	40%
Ambulance Services (ground and air)	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/20%	40%/40%($600 max allow per day)	$15/20%	40%/40% ($600 max allow per day)	$20/20%	40%/40%($600 max allow per day)
Non-severe mental health (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Acute care detoxification	20% ($250 max allow per day)	40% ($250 max allow per day)	20% ($250 max allow per day)	40% ($250 max allow per day)	20% ($250 max allow per day)	40% ($250 max allow per day)
Other Services						
Durable Medical Equipment	20%	40%	20%	40%	20%	40%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	20%	40%	20%	40%	20%	40%
Chiropractic care	$10	40% ($25 max payable per visit)	$15	40% ($25 max payable per visit)	$20	40% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on limited fee schedule. Limited fee schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of allowed amount in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

C & R						
	PPO 500/80/60 ($10) PLAN CODE 3P4		PPO 500/80/60 ($15) PLAN CODE 3P3		PPO 500/80/60 ($20) PLAN CODE 3P2	
Key Benefits	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**	**In-Network**	**Out-of-Network[2]**
Deductible & Plan Maximums						
Annual Deductible						
Individual =	$500 (in and out-of-network combined)		$500 (in and out-of-network combined)		$500 (in and out-of-network combined)	
Family =	$1500 (in and out-of-network combined)		$1500 (in and out-of-network combined)		$1500 (in and out-of-network combined)	
Coinsurance	20%	40%	20%	40%	20%	40%
Maximum out-of-pocket costs						
Individual =	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Family =	$9,000	$18,000	$9,000	$18,000	$9,000	$18,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services						
Office visit copay	$10	40%	$15	40%	$20	40%
Well-child care (through age 16, including child immunization	$10	not covered	$15	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	$10	not covered	$15	not covered	$20	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$10 ($250 max payable per calendar year)	not covered	$15 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	40%	$15	40%	$20	40%
X-ray and Laboratory procedures	20%	40%	20%	40%	20%	40%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per day)		20% ($100 max copay per day)		20% ($100 max copay per day)	
Hospital Services						
Inpatient care	20%	40%	20%	40%	20%	40%
Outpatient Services	20%	40%	20%	40%	20%	40%
Outpatient Surgery	20%	40%	20%	40%	20%	40%
Skilled Nursing Facility	20%	40%	20%	40%	20%	40%
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services						
Emergency Room (deductible waived if admitted)	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%
Urgent Care (deductible waived if admitted)	$10	40%	$15	40%	$20	40%
Ambulance Services (ground and air)	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%
Behavorial Health Services						
Severe mental health (outpatient/inpatient)[3]	$10/20%	40%/40%	$15/20%	40%/40%	$20/20%	40%/40%
Non-severe mental health (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	20%/20%	40%/40%	20%/20%	40%/40%	20%/20%	40%/40%
Acute care detoxification	20%	40%	20%	40%	20%	40%
Other Services						
Durable Medical Equipment	20%	40%	20%	40%	20%	40%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	20%	40%	20%	40%	20%	40%
Chiropractic care	$10	40% ($25 max payable per visit)	$15	40% ($25 max payable per visit)	$20	40% ($25 max payable per visit)
	$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)		$300 max calendar year (in & out-of-network combined)	
Acupuncture	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)
	$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)		$300 max per calendar year (in & out-of-network combined)	
Prescription Drug Coverage						
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary and reasonable in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

SPLIT DEDUCTIBLE	RBRVS		C & R	
	PPO 250/80/60 PLAN CODE 4D1 (formerly 93K)		PPO 250/80/60 PLAN CODE 92V	
Key Benefits	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[2]**
Deductible & Plan Maximums				
Annual Deductible				
Individual =	$250	$500	$250	$500
Family =	$750	$1,500	$750	$1,500
Coinsurance	20%	40%	20%	40%
Maximum out-of-pocket costs				
Individual =	$3,000	$6,000	$3,000	$6,000
Family =	$9,000	$18,000	$9,000	$18,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services				
Office visit copay	$20	40%	$20	40%
Well-child care (through age 16, including child immunization	$20	not covered	$20	not covered
Adult Preventive Care (age 17 and older)	20%	not covered	20%	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$20 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$20	40%	$20	40%
X-ray and Laboratory procedures	20%	40%	20%	40%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20%	40% ($25 max payable per visit)	20%	40% ($25 max payable per visit)
	12 visits per calendar year (in & out-of-network combined)		12 visits per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per script)		20% ($100 max copay per script)	
Hospital Services				
Inpatient care	20%	$500 + 40% ($600 max allow per day)	20%	$500 + 40%
Outpatient Services	20%	40%	20%	40%
Outpatient Surgery	20%	$500 + 40% ($350 max payable per day)	20%	$500 + 40%
Skilled Nursing Facility	20%	$500 + 40% ($250 max payable per day)	20%	$500 + 40%
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services				
Emergency Room (deductible waived if admitted)	$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%
Urgent Care (deductible waived if admitted)	$20	40%	$20	40%
Ambulance Services (ground and air)	$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%
Behavorial Health Services				
Severe mental health (outpatient/inpatient)[3]	$20/20%	40%/$500 + 40%($600 max allow per day)	$20/20%	40%/$500 + 40%
Non-severe mental health (outpatient/inpatient)[4]	20% ($25 max payable per visit/20% ($175 max allow per day)	40% ($25 max payable per visit/40% ($175 max allow per day)	20%/20%	40%/40%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	20% ($25 max payable per visit/20% ($175 max allow per day)	40% ($25 max payable per visit/40% ($175 max allow per day)	20%/20%	40%/40%
Acute care detoxification	20% ($175 max allow per day)	40% ($175 max allow per day)	20%	40%
Other Services				
Durable Medical Equipment	20%	40%	20%	40%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	20%	40%	20%	40%
Chiropractic care	$20	40% ($25 max payable per visit)	$20	40% ($25 max payable per visit)
	12 visits per calendar year (in & out-of-network combined)		12 visits per calendar year (in & out-of-network combined)	
Acupuncture	20%	40%($25 max payable per visit)	20%	40%($25 max payable per visit)
	12 visits per calendar year (in & out-of-network combined)		12 visits per calendar year (in & out-of-network combined)	
Prescription Drug Coverage				
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on limited fee schedule. Limited fee schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of allowed amount in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

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[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year

Commercial Mid-Market/Large Group PPO (with Non-Severe MH) Starting Line-Up Plans

SPLIT DEDUCTIBLE	RBRVS		C & R	
	PPO 250/500/90/70 PLAN CODE 3W9 (formerly 938)		PPO 250/500/90/70 PLAN CODE 936	
Key Benefits	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[2]**
Deductible & Plan Maximums				
Annual Deductible				
Individual =	$250	$500	$250	$500
Family =	$750	$1,500	$750	$1,500
Coinsurance	10%	30%	10%	30%
Maximum out-of-pocket costs				
Individual =	$2,000	$6,000	$2,000	$6,000
Family =	$6,000	$18,000	$6,000	$18,000
Maximum Lifetime Benefit	$5,000,000 (in & out of network combined)		$5,000,000 (in & out of network combined)	
Professional Services				
Office visit copay	$10	30%	$10	30%
Well-child care (through age 16, including child immunization	$10	not covered	$10	not covered
Adult Preventive Care (age 17 and older)	10%	not covered	10%	not covered
Adult Annual Routine Physical Examinations (age 17 and older)	$20 ($250 max payable per calendar year)	not covered	$20 ($250 max payable per calendar year)	not covered
Specialist Consultations	$10	30%	$10	30%
X-ray and Laboratory procedures	10%	30%	10%	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10%	30% ($25 max payable per visit)	10%	30% ($25 max payable per visit)
	12 visits per calendar year (in & out-of-network combined)		12 visits per calendar year (in & out-of-network combined)	
Self Injectables	20% ($100 max copay per script)		20% ($100 max copay per script)	
Hospital Services				
Inpatient care	10%	$500 + 30% ($600 max allow per day)	10%	$500 + 30%
Outpatient Services	10%	30%	10%	30%
Outpatient Surgery	10%	$500 + 30% ($350 max payable per day)	10%	$500 + 30%
Skilled Nursing Facility	10%	$500 + 30% ($250 max allow per day)	10%	$500 + 30%
	100 days per calendar year (in & out-of-network combined)		100 days per calendar year (in & out-of-network combined)	
Emergency Services				
Emergency Room (deductible waived if admitted)	$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
Urgent Care (deductible waived if admitted)	$10	30%	$10	30%
Ambulance Services (ground and air)	$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
Behavorial Health Services				
Severe mental health (outpatient/inpatient)[2]	$10/10%	30% ($50 max allow per day)	$10/10%	30%/$500 + 30%
Non-severe mental health (outpatient/inpatient)[4]	10% ($50 max payable per visit/10% ($250 max allow per day)	30% ($50 max payable per visit/30% ($250 max allow per day)	10%/10%	30%/30%
Chemical dependency rehabilitation (outpatient/inpatient)[4]	10% ($50 max payable per visit/10% ($250 max allow per day)	30% ($50 max payable per visit/30% ($250 max allow per day)	10%/10%	30%/30%
Acute care detoxification	10% ($250 max allow per day)	30% ($250 max allow per day)	10%	30%
Other Services				
Durable Medical Equipment	10%	30%	10%	30%
	$2,000 max per calendar year (in & out-of-network combined)		$2,000 max per calendar year (in & out-of-network combined)	
Diabetic Equipment	10%	30%	10%	30%
Chiropractic care	$10	30% ($25 max payable per visit)	$10	30% ($25 max payable per visit)
	12 visits per calendar year (in & out-of-network combined)		12 visits per calendar year (in & out-of-network combined)	
Acupuncture	10%	30%($25 max payable per visit)	10%	30%($25 max payable per visit)
	12 visits per calendar year (in & out-of-network combined)		12 visits per calendar year (in & out-of-network combined)	
Prescription Drug Coverage				
Prescription drugs	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1] Out-of-network reimbursement based on limited fee schedule. Limited fee schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of allowed amount in addition to the coinsurance shown.

[2] Out-of-network reimbursement based on customary and reasonable. The covered person is responsible for charges in excess of customary an dreasonable in addition to the coinsurance shown.

[3] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children (SED).

[4] There are combined, non-severe mental health care and chemical dependency rehabilitation limitations of 30 visits (outpatient) or 30 days (inpatient) per calendar year