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

RBRVS						
	PPO 0/90/70 ($10) PLAN CODE 2O4		PPO 0/90/70 ($15) PLAN CODE 2O5		PPO 0/90/70 ($20) PLAN CODE 2O6	
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)	$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)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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. Plan is also available with customary and reasonable reimbursement.

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

C & R						
	PPO 0/90/70 ($10) PLAN CODE 2N7		PPO 0/90/70 ($15) PLAN CODE 2N8		PPO 0/90/70 ($20) PLAN CODE 2N9	
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%	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)	$10/10%	30%/30%	$15/10%	30%/30%	$20/10%	30%/30%
Non-severe mental health (outpatient/inpatient)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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 an dreasonable in addition to the coinsurance shown.

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

RBRVS						
	PPO 0/80/60 ($10) PLAN CODE 2O7		PPO 0/80/60 ($15) PLAN CODE 2O8		PPO 0/80/60 ($20) PLAN CODE 2O9	
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)	$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)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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. Plan is also available with customary and reasonable reimbursement.

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

C & R						
	PPO 0/80/60 ($10) PLAN CODE 2O1		PPO 0/80/60 ($15) PLAN CODE 2O2		PPO 0/80/60 ($20) PLAN CODE 2O3	
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%	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)	$10/20%	40%/40%	$15/20%	40%/40%	$20/20%	40%/40%
Non-severe mental health (outpatient/inpatient)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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 an dreasonable in addition to the coinsurance shown.

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

RBRVS						
	PPO 250/90/70 ($10) PLAN CODE 2P7		PPO 250/90/70 ($15) PLAN CODE 2P8		PPO 250/90/70 ($20) PLAN CODE 2P9	
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)	$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)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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. Plan is also available with customary and reasonable reimbursement.

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

C & R						
	PPO 250/90/70 ($10) PLAN CODE 2P1		PPO 250/90/70 ($15) PLAN CODE 2P2		PPO 250/90/70 ($20) PLAN CODE 2P3	
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%	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)	$10/10%	30%/30%	$15/10%	30%/30%	$20/10%	30%/30%
Non-severe mental health (outpatient/inpatient)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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 an dreasonable in addition to the coinsurance shown.

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

RBRVS						
	PPO 250/80/60 ($10) PLAN CODE 2Q1		PPO 250/80/60 ($15) PLAN CODE 2Q2		PPO 250/80/60 ($20) PLAN CODE 2Q3	
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)	$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)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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. Plan is also available with customary and reasonable reimbursement.

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

C & R						
	PPO 250/80/60 ($10) PLAN CODE 2P4		PPO 250/80/60 ($15) PLAN CODE 2P5		PPO 250/80/60 ($20) PLAN CODE 2P6	
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%	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)	$10/20%	40%/40%	$15/20%	40%/40%	$20/20%	40%/40%
Non-severe mental health (outpatient/inpatient)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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 an dreasonable in addition to the coinsurance shown.

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

RBRVS						
	PPO 500/90/70 ($10) PLAN CODE 2R1		PPO 500/90/70 ($15) PLAN CODE 2R2		PPO 500/90/70 ($20) PLAN CODE 2R3	
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)	$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)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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. Plan is also available with customary and reasonable reimbursement.

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

C & R						
	PPO 500/90/70 ($10) PLAN CODE 2Q4		PPO 500/90/70 ($15) PLAN CODE 2Q5		PPO 500/90/70 ($20) PLAN CODE 2Q6	
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%	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)	$10/10%	30%/30%	$15/10%	30%/30%	$20/10%	30%/30%
Non-severe mental health (outpatient/inpatient)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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 an dreasonable in addition to the coinsurance shown.

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

RBRVS						
	PPO 500/80/60 ($10) PLAN CODE 2R4		PPO 500/80/60 ($15) PLAN CODE 2R5		PPO 500/80/60 ($20) PLAN CODE 2R6	
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)	$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)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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. Plan is also available with customary and reasonable reimbursement.

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

C & R						
	PPO 500/80/60 ($10) PLAN CODE 2Q7		PPO 500/80/60 ($15) PLAN CODE 2Q8		PPO 500/80/60 ($20) PLAN CODE 2Q9	
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%	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)	$10/20%	40%/40%	$15/20%	40%/40%	$20/20%	40%/40%
Non-severe mental health (outpatient/inpatient)	not covered		not covered		not covered	
Chemical dependency rehabilitation (outpatient/inpatient)	not covered		not covered		not covered	
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 an dreasonable in addition to the coinsurance shown.

Commercial Mid-Market/Large Group PPO (Severe-Only 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)	$20/20%	40%/$500 + 40%($600 max allow per day)	$20/20%	40%/$500 + 40%
Non-severe mental health (outpatient/inpatient)	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)	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. Plan is also available with customary and reasonable

[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.

Commercial Mid-Market/Large Group PPO (Severe-Only 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)	$10/10%	30% ($50 max allow per day)	$10/10%	30%/$500 + 30%
Non-severe mental health (outpatient/inpatient)[3]	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. Plan is also available with customary and reasonable

[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