

COVERAGES	PERSONAL CHOICE PPO 20/30/70		PERSONAL CHOICE HDHP w/ Integrated Rx	
	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In Network</i>	<i>Out of Network</i>
Deductible Individual/Family	\$0/\$0	\$500/\$1,000	\$1,500/\$3,000	\$5,000/\$10,000
Out of Pocket Maximum Individual/Family	None	\$3,000/\$6,000	\$5,600/\$11,200	\$10,000/\$20,000
Lifetime Maximum	Unlimited	\$1,000,000	Unlimited	\$500,000
Primary Care Office Visit	\$20 Copay	70% after ded.	100%	50% after ded.
Specialist Office Visit	\$30 Copay	70% after ded.	100%	50% after ded.
Maternity Care	\$20 Copay, 1st visit	70% after ded.	100%	50% after ded.
Pediatric Immunizations	100%	70% NO ded.	100%, NO ded	50%, NO ded
Routine Gyn Exam / Pap	100%	70% NO ded.	100%	50%, NO ded
Routine Mammogram	100%	70% NO ded.	100%, NO ded	50%, NO ded
Hospitalization	\$150 Copay/day; max \$750 copay/adm.	70% after ded.	100% after ded.	50% after ded.
Outpatient Radiology	\$30 Copay	70% after ded.	100% after ded.	50% after ded.
Outpatient Laboratory	100%	70% after ded.	100% after ded.	50% after ded.
Emergency Room	\$40 Copay (waived if admitted)	\$40 Copay (waived if admitted); NO ded.	100% after ded.	Covered at in-network level
Outpatient Surgery	\$150 Copay	70% after ded.	100% after ded.	50% after ded.
Restorative Services Including Chiropractic Care	\$30 Copay 30 vists per cal. yr.	70% after ded.	100% after ded.	50% after ded.
Therapy: Physical, Speech and Occup.	\$20 Copay (1-30 visits) \$30 Copay (31-60 visits) 60 visits per cal. yr. Combined in/out of network	70% after ded.	100% after ded. 30 visits/cal yr (Phys & Occup) 20 visits/cal yr (Speech)	50% after ded.
Durable Medical Equipment and Prosthetics	\$30 Copay	70% after ded.	100% after ded.	50% after ded. (\$2,500 benefit max/cal yr)
Prescription Drug	\$15 Generic Formulary \$35 Brand Formulary \$50 Non-Formulary	Covered 30% at a non-participating pharmacy	\$5 Generic Formulary \$20 Brand Formulary \$45 Non-Formulary	50% after ded.
Vision	Freestanding	Freestanding	Freestanding	Freestanding
Inpatient Mental Health	\$150 Copay/day; max \$750 copay/adm.	70% after ded. up to 20 days per cal. yr.	100% after ded. 30 days/yr	50% after ded. 20 days/yr
Outpatient Mental Health	\$30 Copay/visit 30 visits per cal. yr.	50% after ded. 20 vists per cal. yr.	100% after ded.	50% after ded. 20/cal yr
Inpatient Serious Mental Illness	\$150 Copay/day; max \$750 copay/adm.	70% after ded.	100% after ded.	50% after ded. 30 days/yr
Outpatient Serious Mental Illness	\$30 Copay/day 60 days per cal. yr.	50% after ded.	100% after ded.	50% after ded. 60 visits/yr

PLEASE NOTE: FOR SUMMARY PURPOSES ONLY. FOR FURTHER DETAILS, PLEASE REFER TO YOUR CONTRACT BOOKLET.