SIDE-BY-SIDE COMPARISON

	PPO Plan		Basic Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Major Medical Deductible	$500 Individual $1,500 Family	$1,000 Individual $3,000 Family	$1,000 Individual $3,000 Family	$2,000 Individual $6,000 Family
Coinsurance Percent	70%	50%	60%	50%
Out-of-Pocket Max (Includes Deductible)	$3,000 Individual $9,000 Family	$10,000 Individual $25,000 Family	$4,000 Individual $12,000 Family	$10,000 Individual $25,000 Family
Primary Care Physician Office Visit	$5 co-pay then 100%	50% after ded.	$10 co-pay then 100%	50% after ded.
Specialist Office Visit	$10 co-pay then 100%	50% after ded.	$15 co-pay then 100%	50% after ded.
Wellness Physical Exams (Routine Care)	$0 co-pay then 100%	50% after ded.	$0 co-pay then 100%	50% after ded.
Well Child Care (Includes Immunizations)	$0 co-pay then 100%	50% after ded.	$0 co-pay then 100%	50% after ded.
Routine Hearing Exam (1 Per Year)	100% no ded.	50% after ded.	100% no ded.	50% after ded.
Mammogram	100% no ded.	50% after ded.	100% no ded.	50% after ded.
Pap Smear	100% no ded.	50% after ded.	100% no ded.	50% after ded.
Fecal Occult Screening	100% no ded.	50% after ded.	100% no ded.	50% after ded.
Hospital Benefits Inpatient*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Hospital Benefits Outpatient*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Emergency Room**	70% after ded.	70% after ded.	60% after ded.	60% after ded.
Surgical Benefits Inpatient*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Surgical Benefits Outpatient*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Diagnostic Lab & X-Ray	100% no ded.	50% after ded.	100% no ded.	50% after ded.
CT Scans, PET Scans, MRI, & Nuclear Medicine	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Prescription Drug Card	Retail Prescription (30 days): $0 generic •$10 preferred brand •$20 non-preferred •$100 specialty drug Retail Prescription (90 days): $0 generic •$30 preferred brand •$60 non-preferred Mail Order Prescription (90 days): $0 generic •$20 preferred brand •$40 non-preferred			
Mental Nervous & Substance Abuse Inpatient & Outpatient*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Additional Medical Benefits Infusion Therapy	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Home Health Care*	100% no ded.	100% after ded.	100% no ded.	100% after ded.
Skilled Nursing Facility*	100% no ded.	100% after ded.	100% no ded.	100% after ded.
Hospice*	100% no ded.	100% after ded.	100% no ded.	100% after ded.
Birthing Center	100% no ded.	100% after ded.	100% no ded.	100% after ded.
Ambulance Service	70% after ded.	70% after in-net ded.	60% after ded.	60% after in-net ded.
Durable Medical Equipment & Supplies	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Vision (Combined with Medical Plan Includes Exam & All Related Hardware)	100% no ded. Up to a $300 annual maximum			

Dental Benefits	
Annual Deductible	$50 per covered individual
Preventative & Diagnostic	100% no deductible
Basic Restorative Services	80% after $50 deductible
Major Restorative Services (Includes Coverage for Dental Implants)	50% after $50 deductible
Calendar Year Maximum	$2,000 per covered individual

Important: *Precertification is required. You are responsible to call or have your physician call 48 hours before these procedures (phone number on back of ID card) Failure to call will result in up to a $500 penalty!

**** An additional $350 co-pay applies for Non-True Emergency visits.**

This is a general description of benefits for more details please refer to the plan document