



Small Group Plan Designs	PPO								POS					HMO		
	Hi Option	Mid Options		Value Options				Hi Option	Mid Options		Value Options			Hi Option	Mid Option	Value Option
	100	101	102	103	104	105	106 (MSA Eligible)	200	201	202	203	204	205	300	301	302
Lifetime Maximum*																
In-Network	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Network	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	Not Covered	Not Covered	Not Covered
Deductible*																
In-Network	\$300	\$500	\$500	\$1,000	\$1,500	\$2,500	Indiv. \$2,500	Family \$4,950	None	None	None	None	None	None	None	None
Out-of-Network									\$300	\$300	\$500	\$1,000	\$1,500	\$2,500	Not Covered	Not Covered
Coinsurance																
In-Network	90%	80%	80%	80%	80%	80%	80%	90%	100%	80%	100%	80%	80%	80%	100%	80%
Out-of-Network	70%	60%	60%	60%	60%	60%	60%	70%	70%	60%	60%	60%	60%	60%	Not Covered	Not Covered
Out-of-Pocket Maximum for Calendar Year (up to 3 family members ¹) Excludes Deductible																
In-Network	\$1,000	\$1,000	\$2,000	\$1,000	\$2,000	\$2,000	Indiv.* \$3,300	Family* \$6,050	–	\$1,000	–	\$1,000	\$2,000	\$2,000	–	\$2,000
Out-of-Network	\$6,000	\$2,000	\$4,000	\$4,000	\$8,000	\$8,000	\$3,300	\$6,050	\$1,500	\$2,000	\$4,000	\$4,000	\$6,000	\$6,000	Not Covered	Not Covered
Physician Office Visit																
In-Network (PCP/Specialist) Copayment	\$15	\$15	\$15	\$15	\$25/\$35	\$25/\$35	–	–	\$15/\$20	\$15/\$20	\$25	\$15/\$20	\$30	\$35	\$15/\$20	\$15/\$20
# Visits Before Deductible/Coinsurance	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	4	–	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Coinsurance After # Copays	–	–	–	–	–	–	80%	90% (Copays N/A to Plan 106)	–	–	–	–	–	–	–	–
Out-of-Network Coinsurance	70%	60%	60%	60%	60%	60%	60%	70%	70%	60%	60%	60%	60%	60%	Not Covered	Not Covered
Inpatient Hospital																
In-Network Coinsurance/Copayments	90%	80%	80%	\$200	\$300	\$400	90%	–	100%	80%	100%	80%	\$300	\$400	100%	80%
# Copays per Admission	–	–	–	5	5	5	–	–	–	–	–	–	5	5	–	–
After Copays Are Met Plan Pays	–	–	–	100%	100%	100%	–	–	–	–	–	–	100%	100%	–	100%
Out-of-Network Coinsurance per Admission	70%	60%	60%	60%	60%	60%	70%	70%	70%	60%	60%	60%	60%	60%	Not Covered	Not Covered
Inpatient Physician (Anesthesiology, Radiology, etc.)																
In-Network Coinsurance	90%	80%	80%	80%	80%	80%	90%	–	100%	80%	100%	100%	100%	100%	100%	80%
Out-of-Network Coinsurance	70%	60%	60%	60%	60%	60%	70%	70%	70%	60%	60%	60%	60%	60%	Not Covered	Not Covered
Outpatient Surgery Facility																
In-Network	90%	80%	80%	\$200	\$300	\$400	90%	–	\$100	80%	\$100	80%	\$300	\$400	\$100	80%
After Copays Are Met Plan Pays	–	–	–	80%	80%	80%	–	–	100%	–	100%	–	80%	80%	100%	–
Out-of-Network Coinsurance	70%	60%	60%	60%	60%	60%	70%	70%	70%	60%	60%	60%	60%	60%	Not Covered	Not Covered
Outpatient Surgery Physician (Anesthesiology, Radiology, etc.)																
In-Network Coinsurance	90%	80%	80%	80%	80%	80%	90%	–	100%	80%	100%	100%	100%	100%	100%	80%
Out-of-Network Coinsurance	70%	60%	60%	60%	60%	60%	70%	70%	70%	60%	60%	60%	60%	60%	Not Covered	Not Covered
Emergency Room Copay	\$100	\$100	\$100	\$100	\$100	\$150	–	–	\$100	\$100	\$100	\$100	\$100	\$150	\$100	\$100
Mental Health/Substance Abuse																
Inpatient – In-Network Coinsurance/Copayments	80%	80%	80%	\$200	\$300	\$400	80%	–	100%	80%	100%	80%	\$300	\$400	100%	80%
# Copays per Admission	–	–	–	5	5	5	–	–	–	–	–	–	5	5	–	–
Annual Day Limit	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30
Outpatient – In-Network Coinsurance/Copayments	\$25	\$25	\$25	\$25	\$25	\$25	80%	–	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25
Annual Visit Limit	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
Out-of-Network Coinsurance	60%	60%	60%	60%	60%	60%	60%	60%	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Maternity (Physician Fee Only)																
In-Network Coinsurance/Copayments	\$100	\$100	\$100	\$200	\$200	\$300	90%	–	\$20	\$100	\$100	\$100	\$200	\$300	\$20	\$100
Out-of-Network Coinsurance	70%	60%	60%	60%	60%	60%	70%	70%	70%	60%	60%	60%	60%	60%	Not Covered	Not Covered
Physical/Occupational Therapy																
In-Network Coinsurance/Copayments	90%	80%	80%	80%	80%	80%	90%	–	\$20	\$20	\$25	\$20	\$30	\$35	\$20	\$20
Out-of-Network Coinsurance	70%	60%	60%	60%	60%	60%	70%	70%	70%	60%	60%	60%	60%	60%	Not Covered	Not Covered
Annual Visits	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
Rx																
Generic/Formulary	\$15	\$15	\$15	\$15	\$15	\$15	Not Subject to Formulary	–	\$10	\$15	\$15	\$15	\$15	\$15	\$10	\$15
Brand/Formulary	\$25	\$25	\$25	\$30	\$30	\$30	–	–	\$20	\$25	\$25	\$30	\$30	\$30	\$20	\$25
Non-Formulary	\$40	\$40	\$40	\$45	\$45	\$45	90%	–	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Mail Order	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	\$40	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

*Only one PPO deductible and one lifetime benefit maximum applies for both in- and out-of-network.
¹Does not apply for Plan 106-MSA Eligible

Plan 106: All benefits are subject to deductible and coinsurance.

For specific details on all Plans, please refer to the Benefit Summaries.
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