





# Small Group PPO Plans, *continued*

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			1204SX	1510SX	1508SX	1003SX	1202SX	1501SX
<b>Lifetime Maximum</b>		In-network/Out-of-network	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
<b>Calendar Year Deductible</b> <i>(up to three family members)</i>	Individual	In-network	\$1,000	\$1,000	\$1,000	\$2,000	\$1,000	\$1,000
		Out-of-network	\$2,000	\$2,000	\$2,000	\$4,000	\$2,000	\$2,000
	Family	In-network	\$3,000	\$3,000	\$3,000	\$6,000	\$3,000	\$3,000
		Out-of-network	\$6,000	\$6,000	\$6,000	\$12,000	\$6,000	\$6,000
<b>Coinsurance</b>		In-network	90%	80%	80%	100%	90%	80%
		Out-of-network	60%	60%	60%	70%	60%	60%
<b>Calendar Year Out-of-Pocket Maximum</b> <i>(in addition to the Calendar Year Deductible)</i>	Individual	In-network	\$1,000	\$1,000	\$2,000	\$0	\$1,000	\$1,000
		Out-of-network	\$4,000	\$4,000	\$4,000	\$3,000	\$4,000	\$2,000
	Family	In-network	\$3,000	\$3,000	\$6,000	\$0	\$3,000	\$3,000
		Out-of-network	\$12,000	\$12,000	\$12,000	\$9,000	\$12,000	\$6,000
<b>Physician Office Visit PCP/SPC</b> <i>(includes x-ray and lab work in office)</i>		In-network copay	\$25/\$25	\$25/\$25	\$25/\$25	\$25/\$25	\$40/\$40	\$40/\$40
		Out-of-network	60%	60%	60%	70%	60%	60%
<b>Outpatient Surgical Facility/ Ambulatory Surgery Center</b> <i>(includes diagnostic x-ray/lab)</i>		In-network	90%	80%	80%	100%	90%	80%
		Out-of-network	60%	60%	60%	70%	60%	60%
<b>Physician Outpatient Services</b> <i>(surgeon, anesthesiologist, radiologist, etc.)</i>		In-network	90%	80%	80%	100%	90%	80%
		Out-of-network	60%	60%	60%	70%	60%	60%
<b>Maternity</b> <i>(physician fee only)</i>	<i>(1st visit only)</i>	In-network copay	\$100	\$100	\$100	\$100	\$100	\$100
		Out-of-network	60%	60%	60%	70%	60%	60%
<b>Hospital Inpatient Services</b>		In-network	90%	80%	80%	100%	90%	80%
		Out-of-network	60%	60%	60%	70%	60%	60%
<b>Physician Inpatient Hospital Services</b>		In-network	90%	80%	80%	100%	90%	80%
		Out-of-network	60%	60%	60%	70%	60%	60%
<b>Physical and Occupational Therapy, Chiropractic Care, Athletic Trainers</b> <i>(combined specialties)</i>		In-network	90%	80%	80%	100%	90%	80%
		Out-of-network	60%	60%	60%	70%	60%	60%
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
<b>Behavioral Health/Substance Abuse</b>	Inpatient	In-network	90%	80%	80%	100%	80%	80%
		Out-of-network	60%	60%	60%	70%	60%	60%
		Calendar year max	30 days	30 days	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	\$25	\$25	\$25	\$25	\$40	\$40
		Out-of-network	60%	60%	60%	70%	60%	60%
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
<b>Intermediate Level Behavioral Health - Partial Hospitalization Program or Intensive Outpatient Program</b>		In-network	90%	80%	80%	100%	N/A	N/A
		Out-of-network	60%	60%	60%	70%	N/A	N/A
		Calendar year max	10 visits (per program)	10 visits (per program)	5 visits (combined)	10 visits (per program)	N/A	N/A
<b>Emergency Room</b>	Copay*	In-network/Out-of-network	\$100	\$100	\$100	\$100	\$100	\$100
<b>Prescription Drug Copays</b>	Calendar year deductible per member		\$0	\$0	\$0	\$0	\$0	\$0
		Generic Preferred	\$15	\$15	\$15	\$15	\$20	\$20
		Brand Preferred	\$30	\$30	\$30	\$30	\$35	\$35
		Non-Preferred	\$60	\$60	\$60	\$60	\$60	\$60
		Mail Order Generic/Brand	\$30/\$60	\$30/\$60	\$30/\$60	\$30/\$60	\$60/\$60	\$60/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.  
\* ER copay is waived if admitted to the hospital.



# Small Group PPO Plans, *continued*

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			1504SX	1507SX	1203SX	1502SX	1511SX	1505SX
<b>Lifetime Maximum</b>		In-network/Out-of-network	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
<b>Calendar Year Deductible</b> <i>(up to three family members)</i>	Individual	In-network	\$1,000	\$1,000	\$1,500	\$1,500	\$2,000	\$1,500
		Out-of-network	\$2,000	\$2,000	\$3,000	\$3,000	\$4,000	\$3,000
	Family	In-network	\$3,000	\$3,000	\$4,500	\$4,500	\$6,000	\$4,500
		Out-of-network	\$6,000	\$6,000	\$9,000	\$9,000	\$12,000	\$9,000
<b>Coinsurance</b>		In-network	80%	80%	90%	80%	80%	80%
		Out-of-network	60%	80%	60%	60%	60%	60%
<b>Calendar Year Out-of-Pocket Maximum</b> <i>(in addition to the Calendar Year Deductible)</i>	Individual	In-network	\$2,000	\$2,000	\$1,000	\$1,000	\$2,000	\$2,000
		Out-of-network	\$4,000	\$4,000	\$4,000	\$2,000	\$4,000	\$4,000
	Family	In-network	\$6,000	\$6,000	\$3,000	\$3,000	\$6,000	\$6,000
		Out-of-network	\$12,000	\$12,000	\$12,000	\$6,000	\$12,000	\$12,000
<b>Physician Office Visit PCP/SPC</b> <i>(includes x-ray and lab work in office)</i>		In-network copay	\$40/\$40	\$40/\$40	\$40/\$40	\$40/\$40	\$25/\$25	\$40/\$40
		Out-of-network	60%	\$60 copay (coins. does not apply)	60%	60%	60%	60%
<b>Outpatient Surgical Facility/ Ambulatory Surgery Center</b> <i>(includes diagnostic x-ray/lab)</i>		In-network	80%	80%	90%	80%	80%	80%
		Out-of-network	60%	80%	60%	60%	60%	60%
<b>Physician Outpatient Services</b> <i>(surgeon, anesthesiologist, radiologist, etc.)</i>		In-network	80%	80%	90%	80%	80%	80%
		Out-of-network	60%	80%	60%	60%	60%	60%
<b>Maternity</b> <i>(physician fee only)</i>	<i>(1st visit only)</i>	In-network copay	\$100	\$100	\$100	\$100	\$150	\$100
		Out-of-network	60%	80%	60%	60%	60%	60%
<b>Hospital Inpatient Services</b>		In-network	80%	80%	90%	80%	80%	80%
		Out-of-network	60%	80%	60%	60%	60%	60%
<b>Physician Inpatient Hospital Services</b>		In-network	80%	80%	90%	80%	80%	80%
		Out-of-network	60%	80%	60%	60%	60%	60%
<b>Physical and Occupational Therapy, Chiropractic Care, Athletic Trainers</b> <i>(combined specialties)</i>		In-network	80%	80%	90%	80%	80%	80%
		Out-of-network	60%	80%	60%	60%	60%	60%
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
<b>Behavioral Health/Substance Abuse</b>	Inpatient	In-network	80%	80%	80%	80%	80%	80%
		Out-of-network	60%	60%	60%	60%	60%	60%
		Calendar year max	30 days	30 days	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	\$40	\$40	\$40	\$40	\$25	\$40
		Out-of-network	60%	60%	60%	60%	60%	60%
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
<b>Intermediate Level Behavioral Health - Partial Hospitalization Program or Intensive Outpatient Program</b>		In-network	N/A	N/A	N/A	N/A	80%	N/A
		Out-of-network	N/A	N/A	N/A	N/A	60%	N/A
		Calendar year max	N/A	N/A	N/A	N/A	10 visits (per program)	N/A
<b>Emergency Room</b>	Copay*	In-network/Out-of-network	\$100	\$100	\$100	\$100	\$150	\$100
<b>Prescription Drug Copays</b>	Calendar year deductible per member		\$0	\$0	\$0	\$0	\$0	\$0
		Generic Preferred	\$20	\$20	\$20	\$20	\$15	\$20
		Brand Preferred	\$35	\$35	\$35	\$35	\$30	\$35
		Non-Preferred	\$60	\$60	\$60	\$60	\$60	\$60
		Mail Order Generic/Brand	\$60/\$60	\$60/\$60	\$60/\$60	\$60/\$60	\$30/\$60	\$60/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.  
\* ER copay is waived if admitted to the hospital.



# Small Group PPO Plans, *continued*

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			1512SX	1509SX	1513SX	1506SX
<b>Lifetime Maximum</b>		In-network/Out-of-network	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
<b>Calendar Year Deductible</b> <i>(up to three family members)</i>	Individual	In-network	\$2,500	\$2,500	\$3,000	\$3,000
		Out-of-network	\$5,000	\$5,000	\$3,000	\$3,000
	Family	In-network	\$7,500	\$7,500	\$9,000	\$9,000
		Out-of-network	\$15,000	\$15,000	\$9,000	\$9,000
<b>Coinsurance</b>		In-network	80%	80%	80%	80%
		Out-of-network	60%	60%	60%	60%
<b>Calendar Year Out-of-Pocket Maximum</b> <i>(in addition to the Calendar Year Deductible)</i>	Individual	In-network	\$2,000	\$2,000	\$3,000	\$3,000
		Out-of-network	\$4,000	\$4,000	\$6,000	\$15,000
	Family	In-network	\$6,000	\$6,000	\$9,000	\$9,000
		Out-of-network	\$12,000	\$12,000	\$18,000	\$45,000
<b>Physician Office Visit PCP/SPC</b> <i>(includes x-ray and lab work in office)</i>		In-network copay	\$25/\$25	\$25/\$25	\$40/\$50	\$40/\$50
		Out-of-network	60%	60%	60%	60%
<b>Outpatient Surgical Facility/ Ambulatory Surgery Center</b> <i>(includes diagnostic x-ray/lab)</i>		In-network	80%	80%	80%	\$500 copay; 80%
		Out-of-network	60%	60%	60%	60%
<b>Physician Outpatient Services</b> <i>(surgeon, anesthesiologist, radiologist, etc.)</i>		In-network	80%	80%	80%	80%
		Out-of-network	60%	60%	60%	60%
<b>Maternity</b> <i>(physician fee only)</i>	<i>(1st visit only)</i>	In-network copay	\$150	\$150	\$500	\$500
		Out-of-network	60%	60%	60%	60%
<b>Hospital Inpatient Services</b>		In-network	80%	80%	80%	\$500 copay per admission; 80%
		Out-of-network	60%	60%	60%	60%
<b>Physician Inpatient Hospital Services</b>		In-network	80%	80%	80%	80%
		Out-of-network	60%	60%	60%	60%
<b>Physical and Occupational Therapy, Chiropractic Care, Athletic Trainers</b> <i>(combined specialties)</i>		In-network	80%	80%	80%	80%
		Out-of-network	60%	60%	60%	60%
		Calendar year max	20 visits	20 visits	20 visits	20 visits
<b>Behavioral Health/Substance Abuse</b>	Inpatient	In-network	80%	80%	80%	\$500 copay per admission; 80%
		Out-of-network	60%	60%	60%	60%
		Calendar year max	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	\$25	\$25	\$50	\$40
		Out-of-network	60%	60%	60%	60%
		Calendar year max	20 visits	20 visits	20 visits	20 visits
<b>Intermediate Level Behavioral Health - Partial Hospitalization Program or Intensive Outpatient Program</b>		In-network	80%	80%	80%	N/A
		Out-of-network	60%	60%	60%	N/A
		Calendar year max	10 visits (per program)	5 visits (combined)	10 visits (per program)	N/A
<b>Emergency Room</b>	Copay*	In-network/Out-of-network	\$150	\$150	\$150	\$150
<b>Prescription Drug Copays</b>	Calendar year deductible per member		\$0	\$0	\$250	\$250
		Generic Preferred	\$15	\$15	\$20	\$20
		Brand Preferred	\$30	\$30	\$35	\$35
		Non-Preferred	\$60	\$60	\$60	\$60
		Mail Order Generic/Brand	\$30/\$60	\$30/\$60	\$40/\$70	\$60/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.  
\* ER copay is waived if admitted to the hospital.