

# Plan Overview

0/1000/20% (\$5,000 / \$10,000)

PPO

Benefit description	Member responsibility	
	IN-NETWORK	OUT-OF-NETWORK <sup>1</sup>
<b>Plan maximums</b>		
Out-of-pocket maximum (combined with Rx) (Individual / Family)	\$5,000 / \$10,000	\$10,000 / \$30,000
Calendar year deductible (Individual / Family)	\$1,000 / \$3,000	\$2,000 / \$6,000
Coinsurance	20% deductible applies	40% deductible applies
<b>Professional services</b>		
PCP office visit <sup>2</sup>	\$0 deductible waived	40% deductible applies
Specialist office visit <sup>2</sup>	\$20 deductible waived	40% deductible applies
Preventive care services <sup>2</sup>	\$0 deductible waived	Not Covered
Telehealth services through the Select Telehealth Services Provider <sup>3</sup>	\$0 deductible waived	Not Covered
Rehabilitation therapy <sup>4</sup>	20% deductible applies	40% deductible applies
X-ray procedures <sup>2</sup>	\$0 deductible waived	40% deductible applies
Laboratory procedures <sup>2</sup>	\$0 deductible waived	40% deductible applies
Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)	20% deductible applies	40% deductible applies
<b>Facility services</b>		
Outpatient surgery (hospital)	20% deductible applies	40% deductible applies
Outpatient surgery (ambulatory surgery center)	10% deductible applies	40% deductible applies
Inpatient hospital	20% deductible applies	40% deductible applies
Skilled nursing facility (100 day maximum)	20% deductible applies	40% deductible applies
<b>Emergency services</b>		
Urgent care services	\$20 deductible waived	40% deductible applies
Emergency room facility	20% deductible applies	20% deductible applies
Ambulance services (ground and air)	20% deductible applies	40% deductible applies
<b>Mental health and substance use disorder services</b>		
Outpatient office visit	\$0 deductible waived	40% deductible applies
Outpatient other (includes partial hospitalization/day treatment/intensive outpatient programs)	\$0 deductible waived	40% deductible applies
Inpatient	20% deductible applies	40% deductible applies
<b>Other services</b>		
Durable medical equipment <sup>2</sup>	20% deductible applies	40% deductible applies
Diabetic equipment	20% deductible applies	40% deductible applies
Acupuncture services	20% deductible applies	40% deductible applies
Chiropractic services	\$0 deductible waived	40% deductible applies

<sup>1</sup>Out-of-network reimbursement based on maximum allowable amount. The covered person is responsible for charges in excess of maximum allowable charges in addition to the coinsurance shown.

<sup>2</sup>Preventive care services are covered for children and adults based on guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations; the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC); and the guidelines for infants, children, adolescents, and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

<sup>3</sup>Listed cost share is for services provided through the Select Telehealth Services Provider; for all other providers, telehealth cost share mirrors in-person cost share based on type of service provided.

<sup>4</sup>Rehabilitation therapy includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

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