

Select Coverage 3000 90%/60% (WI)

All Plans Available with HRA



Types of Coverage	PPO	Non-PPO*																																																																																														
Out-of-Pocket Expenses <table border="1"> <thead> <tr> <th rowspan="2">Annual Deductible PPO/Non-PPO Options</th> <th rowspan="2">Number of Individual Deductibles</th> <th colspan="2">Copays</th> <th colspan="4">Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)</th> <th colspan="4">Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)</th> </tr> <tr> <th>Office Visit</th> <th>Urgent Care</th> <th>5K/10K</th> <th>10K/20K</th> <th>15K/30K</th> <th>20K/40K</th> <th>5K/10K</th> <th>10K/20K</th> <th>15K/30K</th> <th>20K/40K</th> </tr> </thead> <tbody> <tr> <td>\$250/\$750</td> <td>3</td> <td>\$20</td> <td>\$40</td> <td>\$750</td> <td>\$1,250</td> <td>\$1,750</td> <td>\$2,250</td> <td>\$4,750</td> <td>\$8,750</td> <td>\$12,750</td> <td>\$16,750</td> </tr> <tr> <td>\$500/\$1,500</td> <td>3</td> <td>\$25</td> <td>\$50</td> <td>\$1,000</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> <td>\$5,500</td> <td>\$9,500</td> <td>\$13,500</td> <td>\$17,500</td> </tr> <tr> <td>\$750/\$2,250</td> <td>3</td> <td>\$25</td> <td>\$50</td> <td>\$1,250</td> <td>\$1,750</td> <td>\$2,250</td> <td>\$2,750</td> <td>\$6,250</td> <td>\$10,250</td> <td>\$14,250</td> <td>\$18,250</td> </tr> <tr> <td>\$1,000/\$3,000</td> <td>3</td> <td>\$30</td> <td>\$60</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> <td>\$3,000</td> <td>\$7,000</td> <td>\$11,000</td> <td>\$15,000</td> <td>\$19,000</td> </tr> <tr> <td>\$1,500/\$4,500</td> <td>3</td> <td>\$40</td> <td>\$80</td> <td>\$2,000</td> <td>\$2,500</td> <td>\$3,000</td> <td>\$3,500</td> <td>\$8,500</td> <td>\$12,500</td> <td>\$16,500</td> <td>\$20,500</td> </tr> <tr> <td>\$2,500/\$7,500</td> <td>3</td> <td>ded./coin.</td> <td>ded./coin.</td> <td>\$3,000</td> <td>\$3,500</td> <td>\$4,000</td> <td>\$4,500</td> <td>\$11,500</td> <td>\$15,500</td> <td>\$19,500</td> <td>\$23,500</td> </tr> </tbody> </table> <p><i>Amounts applied toward the PPO deductible do not apply toward satisfaction of the non-PPO deductible and vice versa. Amounts applied toward the PPO out-of-pocket maximum are not credited to the non-PPO out-of-pocket maximum and vice versa.</i></p>	Annual Deductible PPO/Non-PPO Options	Number of Individual Deductibles	Copays		Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)				Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)				Office Visit	Urgent Care	5K/10K	10K/20K	15K/30K	20K/40K	5K/10K	10K/20K	15K/30K	20K/40K	\$250/\$750	3	\$20	\$40	\$750	\$1,250	\$1,750	\$2,250	\$4,750	\$8,750	\$12,750	\$16,750	\$500/\$1,500	3	\$25	\$50	\$1,000	\$1,500	\$2,000	\$2,500	\$5,500	\$9,500	\$13,500	\$17,500	\$750/\$2,250	3	\$25	\$50	\$1,250	\$1,750	\$2,250	\$2,750	\$6,250	\$10,250	\$14,250	\$18,250	\$1,000/\$3,000	3	\$30	\$60	\$1,500	\$2,000	\$2,500	\$3,000	\$7,000	\$11,000	\$15,000	\$19,000	\$1,500/\$4,500	3	\$40	\$80	\$2,000	\$2,500	\$3,000	\$3,500	\$8,500	\$12,500	\$16,500	\$20,500	\$2,500/\$7,500	3	ded./coin.	ded./coin.	\$3,000	\$3,500	\$4,000	\$4,500	\$11,500	\$15,500	\$19,500	\$23,500	<p><i>Family Out-of-Pocket Maximum is three times the Individual Out-of-Pocket Maximum</i></p>	
Annual Deductible PPO/Non-PPO Options			Number of Individual Deductibles	Copays		Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)				Individual Out-of-Pocket Maximum Options (includes deductible and coinsurance)																																																																																						
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Physician/Urgent Care Visits Physician Visits - including office call charges Urgent Care Visits Diagnostic Lab and X-ray - including charges that occur on the same day related to a physician visit or urgent care visit. <i>For \$2,500/\$7,500 ded. option Physician and UC visits and diag. lab/x-ray services are subject to ded./coin. The \$500 first-dollar coverage for diag. lab/x-ray and lab charges does not apply.</i>	100% after office visit copayment 100% after urgent care copayment 100% up to \$500 per calendar year; deductible and coinsurance applies thereafter	60% of usual, customary, and reasonable (UCR) charges after deductible 60% of UCR charges after deductible 60% of UCR charges after deductible																																																																																														
Routine Examinations - \$500 Combined Calendar Year Maximum Includes physical examinations including immunizations, routine mammograms, pap tests, and hearing and vision examinations.	100% after office visit copayment per examination. (For \$2,500/\$7,500 ded., routine benefit paid at 100% w/o copay)	60% of UCR charges after deductible																																																																																														
Physician/Clinic Other Services Includes durable medical equipment, home health care, hospital visits, manipulations, and other physician services. Maximums may apply to some services. See certificate for details.	90% after deductible	60% of UCR charges after deductible																																																																																														
Hospital Services Inpatient care, including semi-private room or intensive care unit, operating room, and ancillary services. Outpatient hospital care, including all medically necessary services and supplies.	90% after deductible	60% of UCR charges after deductible																																																																																														
Emergency Room Care & Facility Charges Includes all services performed in the emergency room, including emergency room physician charges, facility and ambulance.	90% after PPO deductible and \$100 copayment per visit (Note: Non-PPO services are also subject to UCR)																																																																																															
Prescription Drug Program Prescription drug copayments do not apply toward out-of-pocket maximums. Up to a 90 day supply is allowed with mail order option. <i>If there is a tier 1 equivalent available for a tier 2 or non-preferred tier 3 drug, reimbursement will be made at the tier 1 equivalent rate.</i>	Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$25 copayment tier 2, \$50 copayment tier 3 Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$62.50 copayment tier 2, \$125 copayment tier 3 up to a 90 day supply																																																																																															
Mental Health, Alcohol and Drug Abuse Services For groups with 51 or more employees** Maximum inpatient care up to \$7,000 in total eligible charges. Maximum outpatient care up to \$2,000 in total eligible charges. Maximum transitional treatment up to \$3,000 in total charges. Combined treatment arrangements cannot exceed \$7,000/calendar year.	90% after deductible for inpatient, outpatient, and transitional treatment benefits	60% of UCR after deductible for inpatient, outpatient, and transitional treatment benefits																																																																																														
Lifetime Maximum	Combined benefits from all sources not to exceed \$5,000,000																																																																																															

* If provided at a PPO facility, services received from Non-PPO anesthesiologists, radiologists, and pathologists will be eligible for the PPO deductible and coinsurance levels, subject to UCR.

** For groups with 51 or more employees, Mental Health, Alcohol and Drug Abuse Services per calendar year will be paid as follows: All benefits are subject to deductible and coinsurance; for inpatient treatment, benefits are payable for up to 10 days of confinement; for outpatient treatment, benefits are payable for up to 16 visits; for transitional treatment, benefits are payable for up to 12 visits.

All copayments are not credited to the deductible, out-of-pocket or coinsurance. The emergency room facility charge copayment is waived if patient is admitted within 24 hours.

All payment illustrations include payment amounts as indicated for covered benefits, subject to the terms and provisions of the Certificate. The outlined benefits are intended to reflect the coverages provided in the Master Policy. A more detailed explanation of coverage is provided in the Certificate.

Optional Benefits	PPO	Non-PPO
Prescription Drug Program <i>If there is a tier 1 equivalent available for a tier 2 or non-preferred tier 3 drug, reimbursement will be made at the tier 1 equivalent rate.</i> <i>The copayment for the Prescription Drug Program is not credited to the deductible, out-of-pocket or coinsurance.</i>	Participating Pharmacy: 100% of eligible expenses after \$10 copayment tier 1, \$20 copayment tier 2, \$35 copayment tier 3 Mail Order Option: 100% of eligible expenses after \$25 copayment tier 1, \$50 copayment tier 2, \$87.50 copayment tier 3 up to a 90 day supply	
Supplemental Accident Benefit (per calendar year)	\$500	