

HMO PORTFOLIO

Please note: All highlighted boxes reflect standardized benefits between Standard and Value plans. **All HMO plans available with Silver Network.**¹

BENEFIT DESCRIPTION ²	HMO 10		HMO 20	
	STANDARD 888 (\$43)	VALUE 88H (\$46)	STANDARD 883 (\$41)	VALUE 88C (\$47)
PLAN MAXIMUMS				
Out-of-pocket maximum	\$1,500 single \$3,000 family	\$2,000 single \$4,000 family	\$2,000 single \$4,000 family	\$2,500 single \$5,000 family
Lifetime medical benefit maximum	No maximum	No maximum	No maximum	No maximum
PROFESSIONAL SERVICES				
Office visit (including specialist consultation)	\$10 copayment	\$10 copayment	\$20 copayment	\$20 copayment
Periodic health evaluations (including newborn and well-child care, and immunizations)	\$10 copayment (birth through age 2 covered in full)	\$10 copayment (birth through age 2 covered in full)	\$20 copayment (birth through age 2 covered in full)	\$20 copayment (birth through age 2 covered in full)
Adult preventive care (age 17 and older)	\$10 copayment	\$10 copayment	\$20 copayment	\$20 copayment
X-ray and laboratory procedures ³	Covered in full	Covered in full	Covered in full	Covered in full
Rehabilitation therapy ⁴	\$10 copayment	\$10 copayment	\$20 copayment	\$20 copayment
Self-injectable drugs	30%	30%	30%	30%
HOSPITAL SERVICES				
Inpatient hospital facility services (includes maternity)	Covered in full	10%	\$250 copayment per day (3-day copay max/admit)	20%
Outpatient facility services (other than surgery)	Covered in full	10%	20%	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	10%	\$250 copayment	20%
Skilled nursing facility	Days 1–10: covered in full; Days 11–100: \$25 per day	Days 1–10: covered in full; Days 11–100: \$25 per day	Days 1–10: covered in full; Days 11–100: \$25 per day	Days 1–10: covered in full; Days 11–100: \$25 per day
EMERGENCY SERVICES				
Professional services	Covered in full	Covered in full	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
Urgent care facility	\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment
Ambulance services (ground and air)	\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
BEHAVIORAL HEALTH SERVICES⁸				
Severe mental health (outpatient/inpatient)	\$10 copayment/ Covered in full	\$10 copayment/10%	\$20/\$250 per day (3-day copay max/admit)	\$20 copayment/20%
Non-severe mental health (outpatient/inpatient)	\$30 copayment (20 visits/year)/ Covered in full (30 days/year)	\$30 copayment (20 visits/year)/ 10% (30 days/year)	\$30 copayment (20 visits/year)/\$250 copayment per day (3-day copay max/admit) (30 days/year)	\$30 copayment (20 visits/year)/ 20% (30 days/year)
Chemical dependency rehabilitation (outpatient/inpatient)	Not covered	Not covered	Not covered	Not covered
Acute care detoxification	Covered in full	10%	\$250 copayment per day (3-day copay max/admit)	20%
OTHER SERVICES				
Durable medical equipment	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full	Covered in full
Diabetic equipment	20%	20%	20%	20%
Acupuncture, Chiropractic services ⁵	Optional rider available	Optional rider available	Optional rider available	Optional rider available
PRESCRIPTION DRUG COVERAGE⁶				
Brand name calendar year deductible (per member)	No deductible	\$100	No deductible	\$150
Prescription drugs (up to a 30-day supply) ⁷	\$10/\$25/\$50	\$10/\$25/\$50	\$15/\$30/\$50	\$15/\$30/\$50

Plan footnotes found on pages 34–36.

HMO 30		HMO 40	
STANDARD 884 (S42)	VALUE 88D (S45)	STANDARD 885 (S44)	VALUE 88E (S48)
\$3,000 single \$6,000 family	\$3,500 single \$7,000 family	\$4,000 single \$8,000 family	\$4,500 single \$9,000 family
No maximum	No maximum	No maximum	No maximum
\$30 copayment	\$30 copayment	\$40 copayment	\$40 copayment
\$30 copayment (birth through age 2 covered in full)	\$30 copayment (birth through age 2 covered in full)	\$40 copayment (birth through age 2 covered in full)	\$40 copayment (birth through age 2 covered in full)
\$30 copayment	\$30 copayment	\$40 copayment	\$40 copayment
Covered in full	Covered in full	Covered in full	Covered in full
\$30 copayment	\$30 copayment	\$40 copayment	\$40 copayment
30%	30%	30%	30%
\$500 copayment per day (3-day copay max/admit)	30%	\$1,000 copayment per day (3-day copay max/admit)	40%
30%	30%	40%	40%
\$500 copayment	30%	\$1,000 copayment	40%
Days 1–10: covered in full; Days 11–100: \$25 per day	Days 1–10: covered in full; Days 11–100: \$25 per day	Days 1–10: covered in full; Days 11–100: \$25 per day	Days 1–10: covered in full; Days 11–100: \$25 per day
Covered in full	Covered in full	Covered in full	Covered in full
\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment
\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
\$30 copay/\$500 copay per day (3-day copay max/admit)	\$30 copayment/30%	\$40/\$1,000 copay per day (3-day copay max/admit)	\$40 copayment/40%
\$35 copayment (20 visits/year)/ \$500 copayment per day (3-day copay max/admit) (30 days/year)	\$35 copayment (20 visits/year)/ 30% (30 days/year)	\$40 copayment (20 visits/year)/ \$1,000 copayment per day (3-day copay max/admit) (30 days/year)	\$40 copayment (20 visits/year)/ 40% (30 days/year)
Not covered	Not covered	Not covered	Not covered
\$500 copayment per day (3-day copay max/admit)	30%	\$1,000 copayment per day (3-day copay max/admit)	40%
50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)
Covered in full	Covered in full	Covered in full	Covered in full
20%	20%	20%	20%
Optional rider available	Optional rider available	Optional rider available	Optional rider available
No deductible	\$200	No deductible	\$250
\$15/\$30/\$50	\$15/\$30/\$50	\$15/\$30/\$50	\$15/\$30/\$50