EOA PORTFOLIO

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

BENEFIT DESCRIPTION[2]	EOA 10		EOA 20	
	STANDARD (86Z)(7J7)	VALUE (874)(7K2)	STANDARD (871)(7J8)	VALUE (875)(7K3)
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)	HMO: $10 copayment/ PPO: $25 copayment[3]	HMO: $10 copayment/ PPO: $25 copayment[3]	HMO: $20 copayment/ PPO: $35 copayment[3]	HMO: $20 copayment/ PPO: $35 copayment[3]
Periodic health evaluations (including newborn and well-child care, and immunizations)	HMO: $10 copayment (birth through age 2 covered in full), PPO: $25 copayment[3]	HMO: $10 copayment (birth through age 2 covered in full), PPO: $25 copayment[3]	HMO: $20 copayment (birth through age 2 covered in full), PPO: $35 copayment[3]	HMO: $20 copayment (birth through age 2 covered in full), PPO: $35 copayment[3]
Adult preventive care (age 17 and older)	HMO: $10 copayment/ PPO: $25 copayment[3]	HMO: $10 copayment/ PPO: $25 copayment[3]	HMO: $20 copayment/ PPO: $35 copayment[3]	HMO: $20 copayment/ PPO: $35 copayment[3]
X-ray and laboratory procedures[4,5]	Covered in full	Covered in full	Covered in full	Covered in full
Rehabilitation therapy[6]	HMO: $10 copayment, PPO: $25 copayment[3] (12 visits per calendar year)	HMO: $10 copayment, PPO: $25 copayment[3] (12 visits per calendar year)	HMO: $20 copayment, PPO: $35 copayment[3] (12 visits per calendar year)	HMO: $20 copayment, PPO: $35 copayment[3] (12 visits per calendar year)
Self-injectable drugs	30%	30%	30%	30%
HOSPITAL SERVICES[7] 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)[5]	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 SERVICES[11] 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[7]	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[7]	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Diabetic equipment	20%	20%	20%	20%
Acupuncture, Chiropractic services[8]	Optional rider available	Optional rider available	Optional rider available	Optional rider available
PRESCRIPTION DRUG COVERAGE[9] Brand name calendar year deductible (per covered person)	No deductible	$100	No deductible	$150
Prescription drugs (up to a 30-day supply)[10]	$10/$25/$50	$10/$25/$50	$15/$30/$50	$15/$30/$50

Plan footnotes found on pages 31-33.

EOA 30		EOA 40	
STANDARD (872)(7J9)	VALUE (876)(7K4)	STANDARD (873)(7K1)	VALUE (877)(7K5)
$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
HMO: $30 copayment/ PPO: $45 copayment[3]	HMO: $30 copayment/ PPO: $45 copayment[3]	HMO: $40 copayment/ PPO: $55 copayment[3]	HMO: $40 copayment/ PPO: $55 copayment[3]
HMO: $30 copayment (birth through age 2 covered in full), PPO: $45 copayment[3]	HMO: $30 copayment (birth through age 2 covered in full), PPO: $45 copayment[3]	HMO: $40 copayment (birth through age 2 covered in full), PPO: $55 copayment[3]	HMO: $40 copayment (birth through age 2 covered in full), PPO: $55 copayment[3]
HMO: $30 copayment/ PPO: $45 copayment[3]	HMO: $30 copayment/ PPO: $45 copayment[3]	HMO: $40 copayment/ PPO: $55 copayment[3]	HMO: $40 copayment/ PPO: $55 copayment[3]
Covered in full	Covered in full	Covered in full	Covered in full
HMO: $30 copayment, PPO: $45 copayment[3] (12 visits per calendar year)	HMO: $30 copayment, PPO: $45 copayment[3] (12 visits per calendar year)	HMO: $40 copayment, PPO: $55 copayment[3] (12 visits per calendar year)	HMO: $40 copayment, PPO: $55 copayment[3] (12 visits per calendar year)
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
$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