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|  | **PPO** | **HMO** | **Traditional** |
|  |  |  | **Hospitalization/Medical Surgical** | **Major Medical** |
| Deductible | $250 per member / $500 per family | None | Not Applicable | $300 member / $600 family |
| Coinsurance | None | 50% coinsurance, where applicable | 25% coinsurance, where applicable | Coinsurance applies |
| Out-of-Pocket Max | $4,000 member / $8,000 per family | $4,000 member / $8,000 per family | Not Applicable | $700 member / $1,700 family |
| Office Visit | $15 copay | $10 copayment per visit | Not Applicable | Coinsurance applies |
| Specialist | $20 copay | $25 copayment per visit | Not Applicable | Coinsurance applies |
| Urgent Care | $15 copay | Covered in full  | Covered in full |
| Emergency Room | $75 copay, waived if admitted | $75 copayment per visit; waived if admitted | $75 copayment per visit; waived if admitted |
| **Preventive Care** |
| Pediatric/Adult Preventive Care | No charge, waive deductible | Covered in full  | Covered in full | Covered in full, waive deductible |
| Screening Gynecological Exam/Pap Smear | one per benefit period - No charge, waive deductible | One per benefit period - Covered in full, waive deductible  | One per benefit period - Covered in full, waive deductible | Covered in full, waive deductible |
| Screening Mammogram  | one per benefit period - No charge, waive deductible | One per benefit period - Covered in full  | One per benefit period - Covered in full, waive deductible | Covered in full, waive deductible |
| Diagnostic Mammogram | No charge after deductible | Covered in full  | Covered in full | 20% coinsurance after deductible |
| **Facility / Surgical Services** |
| Inpatient Hospital Room and Board | No charge after deductible | Covered in full | Covered in full | 20% Coinsurance after deductible |
| Acute Inpatient Rehabilitation | No charge after deductible | 60 days/benefit period combined – Covered in full | 60 days/benefit period - Covered in full, facility provider, professional provider not covered | 20% coinsurance after deductible |
| Skilled Nursing Facility  | 60 days per benefit period - No charge after deductible | 100 days/benefit period - Covered in full, facility provider, professional provider not covered | 20% coinsurance after deductible |
| Maternity Services and Newborn Care | No charge after deductible | Covered in full | Covered in full | 20% coinsurance after deductible |
| Surgical Procedure and Anesthesia (professional charges) | No charge after deductible | Covered in full | Covered in full | 20% coinsurance after deductible |
| Outpatient Surgery at Ambulatory Surgical Center (facility charge only) | No charge after deductible | Covered in full | Covered in full | 20% coinsurance after deductible |
| Outpatient Surgery at Acute Care Hospital (facility charge only) | No charge after deductible | Covered in full | Covered in full | 20% coinsurance after deductible |
| **Diagnostic Services** |
| High Tech Imaging (such as MRI, CT, PET) | No charge after deductible | Covered in full | Covered in full | 20% coinsurance after deductible |
| Radiology (other than high tech imaging) | No charge after deductible | Covered in full | Covered in full | 20% coinsurance after deductible |
| Independent Laboratory | No charge after deductible | Covered in full | Covered in full | 20% coinsurance after deductible |
| Facility-owned Laboratory (i.e. Health System owned) | No charge after deductible | Covered in full | Covered in full | 20% coinsurance after deductible |
| **Therapy Services** |
| Physical Therapy  | 45 visits per benefit period - $15 copay per visit | 60 consecutive days from the first treatment per condition per lifetime – Covered in full | 30 visits/benefit period - Covered in full facility provider, professional provider not covered  | 30 visits/benefit period - 20% coinsurance after deductible |
| Occupational Therapy | 45 visits per benefit period - $15 copay per visit |
| Speech Therapy  | 45 visits per benefit period - $15 copay per visit |
| Respiratory Therapy | 36 visits per benefit period - $15 copay per visit |
| Manipulation Therapy  | 20 visits per benefit period - $15 copay per visit | 14 consecutive days of acute care service per accident or injury – Covered in full | 20 visits/benefit period – Covered in full | 20 visits/benefit period - 20% coinsurance after deductible |
| **Mental Health / Substance Use Disorder Services** |
| MH Inpatient Services | No charge after deductible | Covered in full | Covered in full for participating facility providers; 25% coinsurance for non-participating facility providers | 20% coinsurance after deductible |
| MH Outpatient Services | $15 copay per visit | Individual Session -$5 copayment per visit Group Session - $5 copayment per visit | Covered under Major Medical | 20% coinsurance after deductible |
| SUD Detoxification Inpatient | No charge after deductible | Covered in full | Covered in full for participating facility providers; 25% coinsurance for non-participating facility providers | 20% coinsurance after deductible |
| SUD Rehabilitation Outpatient | No charge, waive deductible | Individual Session -$5 copayment per visit Group Session - $5 copayment per visit | Covered in full for participating facility providers; 25% coinsurance for non-participating facility providers | 20% coinsurance after deductible |
| **Additional Services** |
| Home Health Care Services | No charge after deductible | 100 visits/benefit period– Covered in full | 90 visits/benefit period - Covered in full, participating facility providers only | 20% coinsurance after deductible |
| Durable Medical Equipment and Supplies | No charge after deductible | Covered in full | Covered under Major Medical | 20% coinsurance after deductible |
| Prosthetic Appliances | No charge after deductible | Covered in full | Covered under Major Medical | 20% coinsurance after deductible |
| Orthotic Devices | No charge after deductible | Covered in full | Covered under Major Medical | 20% coinsurance after deductible |