

PPO Benefit Summary Comparison

Low Deductible Plan

HDHP/HSA Plan

| | PPO Plan 7EK | | HSA Plan 7FI | |
|---|---|---|-------------------|----------------------------------|
| | In Network | Out of Network | In Network | Out of Network |
| Annual Deductible (individual/family) | \$500 / \$1,000 | \$1,000 / \$2,000 | \$1,500 / \$3,000 | \$3,500 / \$7,000 |
| Out-of-Pocket Maximum (individual/family) | \$3,500 / \$7,000 | \$7,000 / \$14,000 | \$2,500 / \$5,000 | \$4,500 / \$9,000 |
| Deductible Included in OOP Max | Included | | Yes | |
| Co-Insurance | 20% for most benefits | 40% for most benefits | 20% | 40% |
| Lifetime Maximum (combined) | \$5,000,000 | | \$5,000,000 | |
| Physician Office Visits | \$20 copay | 40% after deductible | 20% | 40% |
| Specialist Physician Office Visit | \$30 copay | 40% after deductible | 20% | 40% |
| Preventive Care Services | | | | |
| Primary Physician Office Visit | \$20 copay | Not covered | No Charge | Not Covered |
| Specialist Physician Office Visit | \$30 copay | Not covered | No Charge | Not Covered |
| Lab, X-Ray / Other Preventive Tests | \$0 deductible does not apply | Not covered | No Charge | Not Covered |
| Urgent Care | \$50 copay | 40% after deductible | 20% | 40% |
| Emergency Room Services | \$100 copay | | 20% | |
| Hospital - Inpatient Stay | 20% after deductible | 40% after deductible | 20% | 40% |
| Ambulance Services (Ground or Air) | 20% after deductible | | 20% | |
| Dental Services (Accident Only) | 20% after network deductible Limit \$3,000 per year, \$900 per tooth | | 20% | |
| Durable Medical Equipment | 20% after deductible up to \$2,500 per calendar year single purchase | 40% after deductible | 20% | 40% (up to \$2,500/cal yr) |
| Home Health Care | 20% after deductible | 40% after deductible 100 visits per year | 20% | 40% (up to 100 visits/cal yr) |
| Hospice Care - Lab, X-rays and Diagnostics | 20% after deductible | 40% after deductible | 20% | 40% |
| Outpatient - CT, PET, MRI, MRA | \$0 deductible does not apply | 40% after deductible | 20% | 40% |
| Nuclear Medicine | 20% after deductible | 40% after deductible | 20% | 40% |
| Ostomy Supplies | 20% after deductible | 40% after deductible | 20% | 40% |
| Pharmacy | Retail | Mail-Order | Retail | Mail Order |
| Tier 1 | \$10 | \$25 | \$10 | \$25 |
| Tier 2 | \$25 | \$62.50 | \$30 | \$75 |
| Tier 3 | \$45 | \$112.50 | \$50 | \$125 |
| Physician Fees for Surgical and Medical Services | 20% after deductible | 40% after deductible | 20% | 40% |
| Prosthetic Devices | 20% after deductible | 40% after deductible | 20% | 40% |
| Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment | \$20 copay | 40% after deductible | 20% | 40% |
| Limits: | | | | |
| Chiropractic Treatment | 24 visits | | 24 visits/cal yr | |
| Physical Therapy | 20 visits | | 20 visits/cal yr | |
| Occupational Therapy | 20 visits | | 20 visits/cal yr | |
| Speech Therapy | 20 visits | | 20 visits/cal yr | |
| Pulmonary Rehabilitation | 20 visits | | 20 visits/cal yr | |
| Cardiac Rehabilitation | 36 visits | | 36 visits/cal yr | |
| Post-Cochlear Implant aural Therapy | 30 visits | | 30 visits/cal yr | |
| Scopic Procedures - Outpatient Diagnostic and Therapeutic | 20% after deductible | 40% after deductible | 20% | 40% |
| Skilled Nursing Facility | 20% after deductible | 40% after deductible | 20% | 40% (up to 60 days/cal yr) |
| Surgery - Outpatient | 20% after deductible | 40% after deductible | 20% | 40% |
| Therapeutic Treatments - Outpatient Dialysis, Intravenous chemotherapy or other intravenous infusion therapy, radiation oncology | 20% after deductible | 40% after deductible | 20% | 40% |
| Transplantation Services | 20% after deductible | 40% after deductible Benefits are limited to \$30,000 per transplant For Network Benefits, services must be received at a designated facility | 20% | 40% (up to \$30,000/x-plant) |
| Vision Examinations (1 exam every 2 years) | \$20 copay | Not covered | 20% | Not Covered |
| Inpatient Mental Health - Non-Severe | 20% after deductible | 40% after deductible | 20% | 40% (up to 30 days/cal yr) |
| | 30 days per year | | | |

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|-----------------------------------|--|----------------------|---------------------------------|----------------|
| | In Network | Out of Network | In Network | Out of Network |
| Inpatient Substance Abuse | 20% after deductible 30 days per year | 40% after deductible | 20% (up to 30 days/cal yr) | 40% |
| Outpatient Mental Health | \$30 copay 20 visits per year | 40% after deductible | 20% (up to 20 visits/cal yr) | 40% |
| Outpatient Substance Abuse | \$30 copay 20 visits per year | 40% after deductible | 20% (up to 20 visits/cal yr) | 40% |

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

| Rates | Current | Renewal |
|------------------|------------|------------|
| Single | \$774.59 | \$371.11 |
| Dependent | \$1,634.30 | \$783.05 |
| Family | \$2,354.63 | \$1,120.76 |