

# Your benefits at a glance.

	Definity HRA	High Deductible Health Plan	Choice Plus	Choice HMO
Medical	Network / Non-network	Network / Non-network	Network / Non-network	Network
<b>Deductible</b> (*applies)				
Employee	\$1,100	\$1,200 / \$2,400	\$600 / \$1,200	\$600
Employee + Spouse	\$1,900	\$2,400 / \$4,800	\$1,200 / \$2,400	\$900
Employee + Child(ren)	\$1,900	\$2,400 / \$4,800	\$1,200 / \$2,400	\$900
Employee + Family	\$2,750	\$2,400 / \$4,800	\$1,800 / \$3,600	\$1,200
<b>Out-of-Pocket Maximum</b>				
Employee	\$2,500	\$1,800 / \$4,000	\$2,000 / \$4,000 + copays	\$2,000 + copays
Employee + Spouse	\$4,100	\$3,100 / \$7,400	\$3,000 / \$6,000 + copays	\$3,000 + copays
Employee + Child(ren)	\$4,100	\$3,100 / \$7,400	\$3,000 / \$6,000 + copays	\$3,000 + copays
Employee + Family	\$5,700	\$3,100 / \$7,400	\$4,000 / \$8,000 + copays	\$4,000 + copays
<b>HRA Credit Dollars</b>				
Employee	\$500	N/A	N/A	N/A
Employee + Spouse	\$1,000	N/A	N/A	N/A
Employee + Child(ren)	\$1,000	N/A	N/A	N/A
Employee + Family	\$1,500	N/A	N/A	N/A
<b>Pre-existing Conditions</b>	N/A	N/A	\$1,000 per condition	N/A
<b>Lifetime Maximum</b>	\$2 million	\$2 million	\$2 million	\$2 million
<b>Pharmacy</b>	Network 85% * generic 75% * brand Non-network 60% * generic and brand	80% * (\$10 min / \$100 max; no non-network coverage)	Tier 1 – \$15 Tier 2 – \$40 Tier 3 – \$100 (up to a 31-day supply; in-network and non-network)	Tier 1 – \$15 Tier 2 – \$40 Tier 3 – \$75 (up to a 31-day supply)
<b>Physician Visit</b> (medical)	85% / 60% *	90% / 60% *	\$35 copay / 60% *	\$35 copay
<b>Physician Visit</b> (preventive; no non-network coverage)	100%	100%	\$35 copay (\$1,000 annual maximum)	\$35 copay
<b>Injections – In-Office</b> (copay applies if office visit billed)	85% / 60% *	90% / 60% *	\$35 copay (100%) / 60% *	\$35 copay

\* Subject to deductible  
Note: Copayment (copay) required per visit

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Medical	Network / Non-network	Network / Non-network	Network / Non-network	Network
<b>Maternity Care</b> (physician)	85% / 60% *	90% / 60% *	\$35 copay (initial visit only), 80% / 60% *	\$35 copay (initial visit only), 100%
<b>Physician Services</b> (surgical and medical)	85% / 60% *	90% / 60% *	80% / 60% *	80% *
<b>Chiropractic Visit</b> (20 visits per Plan year)	85% / 60% *	90% / 60% *	\$35 copay, 80% / 60% * (in-network not subject to deductible)	\$35 copay
<b>Routine Eye Exam</b> (limited to one exam every 24 months; no non-network coverage)	100%	90%	80%	\$35 copay (\$200 per year for hardware)
<b>Urgent Care Visit</b>	85% / 60% *	90% / 60% *	\$45 copay, 80% / 60% *	\$35 copay
<b>Ambulance</b>	85% *	90% *	80% *	100%
<b>Emergency Room</b> (network and non-network same benefit)	85% *	90% *	\$150 copay (waived if admitted), 80% *	\$150 copay (waived if admitted), 100%
<b>Hospital Stay</b>	85% / 60% *	90% / 60% *	\$250 inpatient copay, ** 80% / 60% *	80% *
<b>Mental Health / Substance Abuse</b> (inpatient)	85% / 60% *	90% / 60% *	\$250 inpatient copay, ** 80% / 60% *	80% *
<b>Mental Health / Substance Abuse</b> (outpatient)	85% / 60% *	90% / 60% *	\$35 copay per office visit / 60% *	\$35 copay
<b>Outpatient Surgery, Diagnostic and Therapeutic Services</b>	85% / 60% *	90% / 60% *	80% / 60% *	80% *
<b>Outpatient Rehabilitation – Physical, Speech, Occupational, Cardiac, Pulmonary Therapy</b> (40 visits per therapy per Plan year)	85% / 60% *	90% / 60% *	\$20 copay, 80% / 60% *	\$25 copay
<b>Home Health Care</b> (prior notification required)	85% / 60% *	90% / 60% *	80% / 60% *	100% (limited to 120 visits per plan year)
<b>Durable Medical Equipment</b> (prior notification required for items over \$1,000)	85% / 60% *	90% / 60% *	80% / 60% *	100%

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\*\* Inpatient copay applies to out-of-pocket

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