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Navigator PPO & VBP Plans

This Schedule of Benefits (SOB) indicates any deductibles, benefit limits, and member responsibility amounts for covered benefits. This is a condensed SOB, please see the full SOB for additional details.

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Navigator PPO Plans.

PPO Prime. PPO Choice. PPO Advantage HDHP. PPO Value.

There are three levels of coverage:

- **Care Advocate:** Coverage applies when you contact a Care Advocate prior to receiving hospital and facility care
- **In-Network:** Coverage applies when you use a Preferred Plan Provider for Covered Benefits
- **Out-of-Network:** Coverage applies when you use a Non-Plan Provider for Covered Benefits

If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or another local emergency number. Your emergency room Member Cost Sharing is listed in the Schedule of Benefits.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please contact member services at 1-866-826-5335 for the complete listing of services that require Prior Approval. Additional information about Prior Approval can be found in your Benefit Handbook.

To obtain Prior Approval please call: 1-866-826-5335 for medical services.

Clinical Review Criteria

Plans use Clinical Review Criteria to evaluate whether certain services or procedures are Medically Necessary for a member's care.

Covered Benefits

Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you have any questions about your Schedule of Benefits or you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call member services at 1-866-826-5335.

Member Cost Sharing will depend upon the type of service provided and the tier each service is accessed, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, Urgent Care, or a free-standing non-facility based setting, see "Physician & Ancillary Services." For services provided in a hospital emergency room, see "Emergency Services," and for outpatient surgical procedures, please see "Outpatient Surgeries" under the Facility-Based Services section.

Navigator PPO Prime
Medical & Pharmacy Plans

		3500 Plan	4000 Plan	4500 Plan	6000 Plan
Tier 1	Deductible (Single / Family)	None	None	None	None
Care Advocate	Out-of-Pocket Limit (Single / Family)	None	None	None	None
Tier 2	Deductible (Single / Family)	$3,500 / $7,000	$4,000 / $8,000	$4,500 / $9,000	$6,000 / $12,000
In-Network PPO	Out-of-Pocket Limit (Single / Family)	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400
Tier 3	Deductible (Single / Family)	$7,000 / $14,000	$8,000 / $16,000	$9,000 / $18,000	$12,000 / $24,000
Out-of-Network	Out-of-Pocket Limit (Single / Family)	Unlimited			

Physician & Ancillary Services	**Care Advocate**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	N/A	$5 Copay (Per Visit)	50% Coinsurance ***
Specialist Office Visit		$50 Copay (Per Visit)	50% Coinsurance ***
Other Services (Performed in Office)		0% Coinsurance **	50% Coinsurance ***
Physician Services (Performed In a Facility)		0% Coinsurance **	50% Coinsurance ***
Urgent Care Visit		$50 Copay (Per Visit)	50% Coinsurance ***
Maternity Physician Services		0% Coinsurance **	50% Coinsurance ***
Lab Services (Non-Hospital)		0% Coinsurance **	50% Coinsurance ***
Rehab & Therapy (Non-Hospital)		0% Coinsurance **	50% Coinsurance ***
Alternative Care (Chiropractic, Acupuncture, Massage Therapy)		$50 Copay (Per Visit)	50% Coinsurance ***
Facility-Based Services		**In-Network**	**Out-of-Network**
Emergency Services Hospital ER (Facility Charge Only)	N/A	$1,000 Copayment †	$1,000 Copayment †††
Ambulance - Emergent (Ground Only)		$500 Copayment **	$500 Copayment ††
Radiology (Hospital Outpatient)		0% Coinsurance **	50% Coinsurance ***
Dialysis & Supplies		$5,200 Copayment **	50% Coinsurance ***
Outpatient Services (Cardiac, Pulmonary, PT, OT, ST)	**$0 Copay / 0% Coinsurance ***	$50 Copayment **	$50 Copayment ††
Outpatient Surgeries	**$0 Copay / 0% Coinsurance ***	$1,000 Copayment **	$1,000 Copayment ††
Inpatient Hospitalizations	**$0 Copay / 0% Coinsurance ***	$1,500 Copayment **	$1,500 Copayment ††
Transplant Procedures	**$0 Copay / 0% Coinsurance ***	$5,200 Copayment **	50% Coinsurance ***
Prescription Drug Benefits		**In-Network**	**Out-of-Network**
Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)	N/A	Generic - $0 Copay	Not Covered
Non-Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)		Generic - $10 Copay Preferred Brand - $20 Copay	Not Covered
Specialty Drugs		50% Coinsurance	Not Covered

* Cannot guarantee a "Care Advocate" option will be available in your area for every medical service or procedure in this category. Some travel may be necessary to receive $0 Copay for larger-cost, non-emergency procedures. ** After Annual Deductible. *** After Annual Deductible plus amounts that exceed the Maximum Allowed Charge. † After Annual Deductible (Copay waived if admitted). †† After Annual Deductible then 50% Coinsurance plus amounts that exceed the Maximum Allowed Charge. ††† After Annual Deductible (Copay waived if admitted) plus amounts that exceed the Maximum Allowable Charge.

The benefit coinsurances and copayments listed above are for Navigator PPO Prime 3500. Please see the full Plan Summaries for Navigator PPO Prime 4000, 4500, and 6000.

Navigator PPO Choice
Medical & Pharmacy Plans

		1000 Plan	1500 Plan	2000 Plan	2500 Plan
Tier 1	Deductible (Single / Family)	None	None	None	None
Care Advocate	Out-of-Pocket Limit (Single / Family)	None	None	None	None
Tier 2	Deductible (Single / Family)	$1,000 / $2,000	$1,500 / $3,000	$2,000 / $4,000	$2,500 / $5,000
In-Network PPO	Out-of-Pocket Limit (Single / Family)	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400
Tier 3	Deductible (Single / Family)	$4,000 / $8,000	$5,000 / $10,000	$6,000 / $12,000	$7,000 / $14,000
Out-of-Network	Out-of-Pocket Limit (Single / Family)	Unlimited			

Physician & Ancillary Services	**Care Advocate**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	N/A	$5 Copay (Per Visit)	50% Coinsurance ***
Specialist Office Visit		$50 Copay (Per Visit)	50% Coinsurance ***
Other Services (Performed in Office)		20% Coinsurance **	50% Coinsurance ***
Physician Services (Performed In a Facility)		20% Coinsurance **	50% Coinsurance ***
Urgent Care Visit		$50 Copay (Per Visit)	50% Coinsurance ***
Maternity Physician Services		20% Coinsurance **	50% Coinsurance ***
Lab Services (Non-Hospital)		20% Coinsurance **	50% Coinsurance ***
Rehab & Therapy (Non-Hospital)		20% Coinsurance **	50% Coinsurance ***
Alternative Care (Chiropractic, Acupuncture, Massage Therapy)		$50 Copay (Per Visit)	50% Coinsurance ***
Facility-Based Services		**In-Network**	**Out-of-Network**
Emergency Services Hospital ER (Facility Charge Only)	N/A	$1,000 Copayment †	$1,000 Copayment ††
Ambulance - Emergent (Ground Only)		$500 Copayment †††	$500 Copayment ‡
Radiology (Hospital Outpatient)		20% Coinsurance **	50% Coinsurance ***
Dialysis & Supplies		$7,700 Copayment **	50% Coinsurance ***
Outpatient Services (Cardiac, Pulmonary, PT, OT, ST)	**$0 Copay / 0% Coinsurance ***	$50 Copayment †††	$50 Copayment ‡
Outpatient Surgeries	**$0 Copay / 0% Coinsurance ***	$1,000 Copayment †††	$1,000 Copayment ‡
Inpatient Hospitalizations	**$0 Copay / 0% Coinsurance ***	$1,500 Copayment †††	$1,500 Copayment ‡
Transplant Procedures	**$0 Copay / 0% Coinsurance ***	$7,700 Copayment **	50% Coinsurance ***
Prescription Drug Benefits		**In-Network**	**Out-of-Network**
Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)	N/A	Generic - $0 Copay	Not Covered
Non-Preventative Prescription Services (Prescription Drugs, Pharmacy Retail – 30-Day Supply)		Generic - $10 Copay Preferred Brand - $20 Copay	Not Covered
Specialty Drugs		50% Coinsurance	Not Covered

* Cannot guarantee a "Care Advocate" option will be available in your area for every medical service or procedure in this category. Some travel may be necessary to receive $0 Copay for larger-cost, non-emergency procedures. ** After Annual Deductible. *** After Annual Deductible plus amounts that exceed the Maximum Allowed Charge. † After Annual Deductible, then 20% coinsurance (Copay waived if admitted). †† After Annual Deductible then 20% Coinsurance (copay waived if admitted) plus amounts that exceed the Maximum Allowed Charge. ††† After Annual Deductible then 20% coinsurance. ‡ After Annual Deductible, then 50% coinsurance plus amounts that exceed the Maximum Allowable Charge.

The benefit coinsurances and copayments listed above are for Navigator PPO Choice 1000. Please see the full Plan Summaries for Navigator PPO Choice 1500, 2000, and 2500.

Navigator PPO Advantage HDHP
Medical & Pharmacy Plans

		4000 Plan	4500 Plan	6000 Plan	6500 Plan
Tier 1	Deductible (Single / Family)	None	None	None	None
Care Advocate	Out-of-Pocket Limit (Single / Family)	None	None	None	None
Tier 2	Deductible (Single / Family)	$4,000 / $8,000	$4,500 / $9,000	$6,000 / $12,000	$6,500 / $13,000
In-Network PPO	Out-of-Pocket Limit (Single / Family)	$7,050 / $14,100	$7,050 / $14,100	$7,050 / $14,100	$7,050 / $14,100
Tier 3	Deductible (Single / Family)	$8,000 / $16,000	$9,000 / $18,000	$12,000 / $24,000	$13,000 / $26,000
Out-of-Network	Out-of-Pocket Limit (Single / Family)	Unlimited			

Physician & Ancillary Services	**Care Advocate**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	N/A	20% Coinsurance **	50% Coinsurance ***
Specialist Office Visit		20% Coinsurance **	50% Coinsurance ***
Other Services (Performed in Office)		20% Coinsurance **	50% Coinsurance ***
Physician Services (Performed In a Facility)		20% Coinsurance **	50% Coinsurance ***
Urgent Care Visit		20% Coinsurance **	50% Coinsurance ***
Maternity Physician Services		20% Coinsurance **	50% Coinsurance ***
Lab Services (Non-Hospital)		20% Coinsurance **	50% Coinsurance ***
Rehab & Therapy (Non-Hospital)		20% Coinsurance **	50% Coinsurance ***
Alternative Care (Chiropractic, Acupuncture, Massage Therapy)		20% Coinsurance **	50% Coinsurance ***
Facility-Based Services		**In-Network**	**Out-of-Network**
Emergency Services Hospital ER (Facility Charge Only)	N/A	20% Coinsurance **	50% Coinsurance ***
Ambulance - Emergent (Ground Only)		20% Coinsurance **	50% Coinsurance ***
Radiology (Hospital Outpatient)		20% Coinsurance **	50% Coinsurance ***
Dialysis & Supplies		$3,050 Copayment **	50% Coinsurance ***
Outpatient Services (Cardiac, Pulmonary, PT, OT, ST)	**$0 Copay / 0% Coinsurance ***	20% Coinsurance **	50% Coinsurance ***
Outpatient Surgeries	**$0 Copay / 0% Coinsurance ***	20% Coinsurance **	50% Coinsurance ***
Inpatient Hospitalizations	**$0 Copay / 0% Coinsurance ***	20% Coinsurance **	50% Coinsurance ***
Transplant Procedures	**$0 Copay / 0% Coinsurance ***	$3,050 Copayment **	50% Coinsurance ***
Prescription Drug Benefits		**In-Network**	**Out-of-Network**
Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)	N/A	Generic $0 Copay	Not Covered
Non-Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)		Generic / Preferred Brand - 20% Coinsurance **	Not Covered
Specialty Drugs		20% Coinsurance **	Not Covered

* Cannot guarantee a "Care Advocate" option will be available in your area for every medical service or procedure in this category. Some travel may be necessary to receive $0 Copay for larger-cost, non-emergency procedures. ** After Annual Deductible. *** After Annual Deductible plus amounts that exceed the Maximum Allowed Charge.

The benefit coinsurances and copayments listed above are for Navigator PPO Advantage HDHP 4000. Please see the full Plan Summaries for Navigator PPO Advantage HDHP 4500, 6000, and 6500.

Navigator PPO Value
Medical & Pharmacy Plans

		2500 Plan	3500 Plan	6850 Plan
Tier 1	Deductible (Single / Family)	None	None	None
Care Advocate	Out-of-Pocket Limit (Single / Family)	None	None	None
Tier 2	Deductible (Single / Family)	$2,500 / $5,000	$3,500 / $7,000	$6,850 / $13,700
In-Network PPO	Out-of-Pocket Limit (Single / Family)	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400
Tier 3	Deductible (Single / Family)	$7,000 / $14,000	$9,000 / $18,000	$15,700 / $31,400
Out-of-Network	Out-of-Pocket Limit (Single / Family)	Unlimited		

Physician & Ancillary Services	**Care Advocate**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	N/A	$5 Copay (Per Visit)	70% Coinsurance ***
Specialist Office Visit		$50 Copay (Per Visit)	70% Coinsurance ***
Other Services (Performed in Office)		50% Coinsurance **	70% Coinsurance ***
Physician Services (Performed In a Facility)		50% Coinsurance **	70% Coinsurance ***
Urgent Care Visit		$50 Copay (Per Visit)	70% Coinsurance ***
Maternity Physician Services		50% Coinsurance **	70% Coinsurance ***
Lab Services (Non-Hospital)		50% Coinsurance **	70% Coinsurance ***
Rehab & Therapy (Non-Hospital)		50% Coinsurance **	70% Coinsurance ***
Alternative Care (Chiropractic, Acupuncture, Massage Therapy)		$50 Copay (Per Visit)	70% Coinsurance ***
Facility-Based Services		**In-Network**	**Out-of-Network**
Emergency Services Hospital ER (Facility Charge Only)	N/A	$1,000 Copay ‡	$1,000 Copay ‡‡
Ambulance - Emergent (Ground Only)		$500 Copay †††	$500 Copay ††
Radiology (Hospital Outpatient)		50% Coinsurance **	70% Coinsurance ***
Dialysis & Supplies		$6,200 Copayment **	70% Coinsurance ***
Outpatient Services (Cardiac, Pulmonary, PT, OT, ST)	**$0 Copay / 0% Coinsurance ***	$50 Copay †††	$50 Copay ††
Outpatient Surgeries	**$0 Copay / 0% Coinsurance ***	$1,000 Copay †††	$1,000 Copay ††
Inpatient Hospitalizations	**$0 Copay / 0% Coinsurance ***	$1,500 Copay †††	$1,500 Copay ††
Transplant Procedures	**$0 Copay / 0% Coinsurance ***	$6,200 Copayment **	70% Coinsurance ***
Prescription Drug Benefits		**In-Network**	**Out-of-Network**
Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)	N/A	Generic - $0 Copay	Not Covered
Non-Preventative Prescription Services (Prescription Drugs, Pharmacy Retail – up to a 30-Day Supply)		Generic - $10 Copay Preferred Brand - $20 Copay	Not Covered
Specialty Drugs		50% Coinsurance	Not Covered

* Cannot guarantee a "Care Advocate" option will be available in your area for every medical service or procedure in this category. Some travel may be necessary to receive $0 Copay for larger-cost, non-emergency procedures. ** After Annual Deductible. *** After Annual Deductible plus amounts that exceed the Maximum Allowed Charge. † After Annual Deductible then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge. †† After Annual Deductible then 70% Coinsurance plus amounts that exceed the Maximum Allowable Charge. ††† After Annual Deductible, then 50% Coinsurance. ‡ After Annual Deductible, then 50% Coinsurance (copay waived if admitted). ‡‡ After Annual Deductible, then 50% Coinsurance (Copay waived if admitted) plus amounts that exceed the Maximum Allowable Charge

The benefit coinsurances and copayments listed above are for Navigator PPO Value 2500. Please see the full Plan Summaries for Navigator PPO Value 3500 and 6850.

Navigator VBP Plans.

Navigator VBP. Navigator VBP HDHP.

There are three levels of coverage:

- **In-Network**: Coverage applies when you use a Preferred Plan Provider for Covered Benefits
- **Out-of-Network:** Coverage applies when you use a Non-Plan Provider for Covered Benefits
- **Value-Based Payment (VBP):** Coverage applies when accessing certain types of providers and services including but not limited to Facilities, Dialysis, and Ambulance

For services obtained under the VBP option, providers will be reimbursed based on the "Maximum Allowable Charge."

If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or another local emergency number. Your emergency room Member Cost Sharing is listed in the Schedule of Benefits.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please contact member services at 1-866-826-5335 for the complete listing of services that require Prior Approval. Additional information about Prior Approval can be found in your Benefit Handbook.

To obtain Prior Approval please call: 1-866-826-5335 for medical services.

Clinical Review Criteria

Plans use Clinical Review Criteria to evaluate whether certain services or procedures are Medically Necessary for a member's care.

Covered Benefits

Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you have any questions about your Schedule of Benefits or you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call member services at 1-866-826-5335.

Member Cost Sharing will depend upon the type of service provided and the tier each service is accessed, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, Urgent Care, or a free-standing non-facility based setting, see "Physician & Ancillary Services." For services provided in a hospital emergency room, see "Emergency Services," and for outpatient surgical procedures, please see "Outpatient Surgeries" under the Facility-Based Services section.

Navigator VBP
Medical & Pharmacy Plans

		1000 Plan	2000 Plan	3000 Plan	5000 Plan
Tier 1	Deductible (Single / Family)	$1,000 / $3,000	$2,000 / $6,000	$3,000 / $6,000	$5,000 / $10,000
In-Network	Out-of-Pocket Limit (Single / Family)	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400
Tier 2	Deductible (Single / Family)	$2,000 / $6,000	$4,000 / $12,000	$6,000 / $12,000	$10,000 / $20,000
Out-of-Network	Out-of-Pocket Limit (Single / Family)	$17,400 / $34,800	$17,400 / $34,800	$17,400 / $34,800	$17,400 / $34,800

Physician & Ancillary Services	**In-Network**	**Out-of-Network**
Primary Care Office Visit	$35 Copay (Per Visit)	40% Coinsurance **
Specialist Office Visit	$35 Copay (Per Visit)	40% Coinsurance **
Other Services (Performed in Office)	20% Coinsurance *	40% Coinsurance **
Physician Services (Performed In a Facility or ER)	20% Coinsurance *	20% Coinsurance **
Urgent Care Visit	$75 Copay (Per Visit)	40% Coinsurance **
Maternity Physician Services	20% Coinsurance *	40% Coinsurance **
Lab Services (Non-Hospital)	Covered in Full	40% Coinsurance **
Rehab & Therapy (Non-Hospital)	$35 Copay (Per Visit)	40% Coinsurance **
Alternative Care (Chiropractic, Acupuncture, Massage Therapy)	$35 Copay (Per Visit)	40% Coinsurance **
Facility-Based Services		
Emergency Services Hospital ER (Facility Charge Only)	$150 Copayment ***	
Ambulance - Emergent (Ground Only)	$200 Copayment †	
Radiology (Hospital Outpatient)	20% Coinsurance †† ‡	
Outpatient Services (Cardiac, Pulmonary, PT, OT, ST)	20% Coinsurance †† ‡	
Outpatient Surgeries	$150 Copayment *** ‡	
Inpatient Hospitalizations	$450 Copayment † ‡	
Dialysis & Supplies	20% Coinsurance ††	
Prescription Drug Benefits	**In-Network**	**Out-of-Network**
Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-day supply)	Generic - $0 Copay	Not Covered
Non-Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)	Generic - $10 Copay Preferred Brand - $20 Copay	Not Covered
Specialty Drugs	50% Coinsurance	Not Covered

* After Annual Deductible. ** After Annual Deductible plus amounts that exceed the Maximum Allowed Charge. *** Plus amounts that exceed the Maximum Allowable Charge (waived if admitted to Inpatient status) † Plus amounts that exceed the Maximum Allowable Charge. †† After Annual Deductible plus amounts that exceed the Maximum Allowed Charge. In-Network Annual Deductible and Annual Out-of-Pocket Maximum applies. Amounts in excess of the Maximum Allowable Charge DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum. ‡ In certain cases, when the member works with a Care Advocate and chooses to be redirected, member cost sharing may be waived.

The benefit coinsurances and copayments listed above are for Navigator VBP 1000. Please see the full Plan Summaries for Navigator VBP 2000, 3000, and 5000.

Navigator VBP HDHP
Medical & Pharmacy Plans

		3000 Plan	5000 Plan
Tier 1	Deductible (Single / Family)	$3,000 / $6,000	$5,000 / $10,000
In-Network	Out-of-Pocket Limit (Single / Family)	$7,050 / $14,100	$7,050 / $14,100
Tier 2	Deductible (Single / Family)	$6,000 / $12,000	$10,000 / $20,000
Out-of-Network	Out-of-Pocket Limit (Single / Family)	$8,000 / $16,000	$13,200 / $26,400

Physician & Ancillary Services	**In-Network**	**Out-of-Network**
Primary Care Office Visit	20% Coinsurance *	50% Coinsurance **
Specialist Office Visit	20% Coinsurance *	50% Coinsurance **
Other Services (Performed in Office)	20% Coinsurance *	50% Coinsurance **
Physician Services (Performed In a Facility or ER)	20% Coinsurance *	50% Coinsurance **
Urgent Care Visit	20% Coinsurance *	50% Coinsurance **
Maternity Physician Services	20% Coinsurance *	50% Coinsurance **
Lab Services (Non-Hospital)	20% Coinsurance *	50% Coinsurance **
Rehab & Therapy (Non-Hospital)	20% Coinsurance *	50% Coinsurance **
Alternative Care (Chiropractic, Acupuncture, Massage Therapy)	20% Coinsurance *	50% Coinsurance **
Facility-Based Services		
Emergency Services Hospital ER (Facility Charge Only)	20% Coinsurance ***	
Ambulance - Emergent (Ground Only)	20% Coinsurance ***	
Radiology (Hospital Outpatient)	20% Coinsurance *** †	
Outpatient Services (Cardiac, Pulmonary, PT, OT, ST)	20% Coinsurance *** †	
Outpatient Surgeries	20% Coinsurance *** †	
Inpatient Hospitalizations	20% Coinsurance *** †	
Dialysis & Supplies	20% Coinsurance ††	
Prescription Drug Benefits	**In-Network**	**Out-of-Network**
Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)	Generic - $0 Copayment	Not Covered
Non-Preventative Prescription Services (Prescription Drugs, Pharmacy Retail - up to a 30-Day Supply)	20% Coinsurance *	Not Covered
Specialty Drugs	20% Coinsurance *	Not Covered

* After Annual Deductible. ** After Annual Deductible plus amounts that exceed the Maximum Allowed Charge. *** After Annual Deductible plus amounts that exceed the Maximum Allowable Charge. In-Network Annual Deductible and Annual Out-of-Pocket Maximum applies. Amounts in excess of the Maximum Allowable Charge DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum. † In certain cases, when the member works with a Care Advocate and chooses to be redirected, member cost sharing may be waived.