

Plan Summaries

2007 HMO, MULTI-CHOICE AND CUSTOM CARE HEALTHINVESTOR (HSA)



Effective as of April 1, 2007

HMO PLANS

HMO A

HMO B

Deductible (Individual/Family)	None	None
Coinsurance Out-of-Pocket Max (Individual/Family)	Not applicable	Not applicable
Maximum Benefit while covered	Unlimited ¹	Unlimited ¹
Coinsurance (after annual deductible)	Not applicable	Not applicable
Office Services		
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$15 copay \$25 copay \$25 copay Plan pays 100% Plan pays 100%	\$20 copay \$30 copay \$30 copay Plan pays 100% Plan pays 100%
Outpatient Services		
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 100% Plan pays 100% \$50 copay \$25 copay \$50 copay Plan pays 100%	Plan pays 100% Plan pays 100% \$50 copay \$30 copay \$100 copay Plan pays 100%
Emergency Services		
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$30 copay \$100 copay	\$100 copay \$40 copay \$100 copay
Inpatient Services		
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	\$200 copay Plan pays 100%	\$500 copay Plan pays 100%
Mental Health Services		
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$25 copay \$200 copay Plan pays 100%	\$30 copay \$500 copay Plan pays 100%
Pharmacy Services– 30-day supply		
<ul style="list-style-type: none"> ■ Generic Drugs ■ Brand Preferred Drugs ■ Brand Non-Preferred Drugs ■ Brand Rx Deductible (Not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay Not applicable Not applicable Unlimited	\$10 copay \$20 copay Not applicable Not applicable Unlimited
Other Services		
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 50% \$25 copay	Plan pays 50% \$30 copay

Footnotes:

1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2.

HMO PLANS

HMO C

HMO D

Deductible (Individual/Family)	\$250/\$750	\$500/\$1,500
Coinsurance Out-of-Pocket Max (Individual/Family)	\$2,000/\$6,000	\$2,000/\$6,000
Maximum Benefit while covered	Unlimited ¹	Unlimited ¹
Coinsurance (after annual deductible)	Plan pays 90%	Plan pays 80%

Office Services

<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$20 copay \$30 copay Plan pays 90% Plan pays 100% ³ Plan pays 100% ³	\$25 copay \$35 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³
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Outpatient Services

<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90%	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%
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Emergency Services

<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$40 copay \$100 copay	\$100 copay \$50 copay \$100 copay
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Inpatient Services

<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90%	Plan pays 80% Plan pays 80%
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Mental Health Services

<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$30 copay Plan pays 90% Plan pays 90%	\$35 copay Plan pays 80% Plan pays 80%
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Pharmacy Services– 30-day supply

<ul style="list-style-type: none"> ■ Generic Drugs ■ Brand Preferred Drugs ■ Brand Non-Preferred ■ Brand Rx Deductible (Not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay Not applicable Not applicable Unlimited	\$10 copay \$20 copay Not applicable \$150 Unlimited
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Other Services

<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 90% \$30 copay	Plan pays 80% \$35 copay
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Footnotes:

1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2.

3 Deductible does not apply.

HMO PLANS

HMO E

Deductible (Individual/Family)	\$1,000/\$3,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$2,000/\$6,000
Maximum Benefit while covered	Unlimited ¹
Coinsurance (after annual deductible)	Plan pays 80%

Office Services

<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$35 copay \$45 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³
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Outpatient Services

<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%
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Emergency Services

<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$70 copay \$100 copay
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Inpatient Services

<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80%
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Mental Health Services

<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$45 copay Plan pays 80% Plan pays 80%
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Pharmacy Services– 30-day supply

<ul style="list-style-type: none"> ■ Generic Drugs ■ Brand Preferred Drugs ■ Brand Non-Preferred Drugs ■ Brand Rx Deductible (Not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay Not applicable \$150 Unlimited
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Other Services

<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 80% \$45 copay
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Footnotes:

1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2.

3 Deductible does not apply.

NEW PLAN!

HMO PLANS

HMO F

HMO F-100

Deductible (Individual/Family)	\$2,000/\$6,000	\$2,000/\$6,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$2,000/\$6,000	Not applicable
Maximum Benefit while covered	Unlimited ¹	Unlimited ¹
Coinsurance (after annual deductible)	Plan pays 70%	Plan pays 100%
Office Services		
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$40 copay \$50 copay Plan pays 70% Plan pays 100% ³ Plan pays 100% ³	\$40 copay \$50 copay Plan pays 100% Plan pays 100% ³ Plan pays 100% ³
Outpatient Services		
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%	Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100%
Emergency Services		
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$150 copay \$80 copay \$150 copay	\$150 copay \$80 copay \$150 copay
Inpatient Services		
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 70% Plan pays 70%	Plan pays 100% Plan pays 100%
Mental Health Services		
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$50 copay Plan pays 70% Plan pays 70%	\$50 copay Plan pays 100% Plan pays 100%
Pharmacy Services– 30-day supply		
<ul style="list-style-type: none"> ■ Generic Drugs ■ Brand Preferred Drugs ■ Brand Non-Preferred Drugs ■ Brand Rx Deductible (Not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay Not applicable \$150 Unlimited	\$10 copay \$20 copay Not applicable \$150 Unlimited
Other Services		
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 70% \$50 copay	Plan pays 100% \$50 copay

Footnotes:

- 1 Some benefits may have limitations.
- 2 Office visit copays may apply. Well-Child Visit: No charge up to age 2.
- 3 Deductible does not apply.

HMO PLANS

NEW PLAN!

NEW PLAN!

HMO G-100

HMO H

Deductible (Individual/Family)	\$1,000/\$3,000	\$3,000/\$9,000
Coinsurance Out-of-Pocket Max (Individual/Family)	Not applicable	\$2,000/\$6,000
Maximum Benefit while covered	Unlimited ¹	Unlimited ¹
Coinsurance (after annual deductible)	Plan pays 100%	Plan pays 70%
Office Services		
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$40 copay \$50 copay Plan pays 100% Plan pays 100% ³ Plan pays 100% ³	\$40 copay \$50 copay Plan pays 70% Plan pays 100% ³ Plan pays 100% ³
Outpatient Services		
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100%	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%
Emergency Services		
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$150 copay \$80 copay \$150 copay	\$150 copay \$80 copay \$150 copay
Inpatient Services		
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 100% Plan pays 100%	Plan pays 70% Plan pays 70%
Mental Health Services		
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$50 copay Plan pays 100% Plan pays 100%	\$50 copay Plan pays 70% Plan pays 70%
Pharmacy Services– 30-day supply		
<ul style="list-style-type: none"> ■ Generic Drugs ■ Brand Preferred Drugs ■ Brand Non-Preferred Drugs ■ Brand Rx Deductible (Not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay Not applicable \$150 Unlimited	\$10 copay \$20 copay Not applicable \$150 Unlimited
Other Services		
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 100% \$50 copay	Plan pays 70% \$50 copay

Footnotes:

1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice Max Plan A

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$200/\$600	\$400/\$1,200	\$600/\$1,800
Coinsurance Out-of-Pocket Max (Individual/Family)	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 90%	Plan pays 90%	Plan pays 70%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$10 copay \$20 copay Plan pays 90% Plan pays 100% ³ Plan pays 100% ³	\$20 copay \$30 copay Plan pays 90% Plan pays 100% ³ Plan pays 100% ³	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90%	Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$20 copay \$100 copay	\$100 copay \$40 copay \$100 copay	\$100 copay Plan pays 70% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90%	Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$20 copay Plan pays 90% Plan pays 90%	\$30 copay Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70% Plan pays 70%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (Not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay Not applicable	\$15 copay \$35 copay \$50 copay Not applicable
		\$5,000 combined	
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 90% \$20 copay	Plan pays 90% Limited to \$250 annually combined. \$30 copay	Plan pays 70% Plan pays 70%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice Max Plan B

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$300/\$900	\$500/\$1,500	\$1,000/\$3,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 80%	Plan pays 80%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$15 copay \$25 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	\$25 copay \$35 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$30 copay \$100 copay	\$100 copay \$50 copay \$100 copay	\$100 copay Plan pays 60% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80%	Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$25 copay Plan pays 80% Plan pays 80%	\$35 copay Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay Not applicable \$5,000 combined	\$15 copay \$35 copay \$50 copay Not applicable
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 80% \$25 copay	Plan pays 80% Limited to \$250 annually combined. \$35 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice Max Plan C

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$500/\$1,500	\$750/\$2,250	\$1,500/\$4,500
Coinsurance Out-of-Pocket Max (Individual/Family)	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 80%	Plan pays 80%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$25 copay \$35 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	\$35 copay \$45 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$50 copay \$100 copay	\$100 copay \$70 copay \$100 copay	\$100 copay Plan pays 60% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80%	Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$35 copay Plan pays 80% Plan pays 80%	\$45 copay Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$15 copay \$30 copay \$45 copay Not applicable Unlimited	\$20 copay \$45 copay \$60 copay \$150 Combined \$5,000 combined	\$20 copay \$45 copay \$60 copay
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 80% \$35 copay	Plan pays 80% Limited to \$250 annually combined. \$45 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice Max Plan D

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$750/\$2,250	\$1,000/\$3,000	\$2,000/\$6,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 80%	Plan pays 80%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$25 copay \$35 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	\$35 copay \$45 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$50 copay \$100 copay	\$100 copay \$70 copay \$100 copay	\$100 copay Plan pays 60% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80%	Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$35 copay Plan pays 80% Plan pays 80%	\$45 copay Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay \$150 combined \$5,000 combined	\$15 copay \$35 copay \$50 copay
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 80% \$35 copay	Plan pays 80% Limited to \$250 annually combined. \$45 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice Max Plan E

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$2,000/\$6,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 70%	Plan pays 70%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$25 copay \$35 copay Plan pays 70% Plan pays 100% ³ Plan pays 100% ³	\$35 copay \$45 copay Plan pays 70% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$50 copay \$100 copay	\$100 copay \$70 copay \$100 copay	\$100 copay Plan pays 60% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 70% Plan pays 70%	Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$35 copay Plan pays 70% Plan pays 70%	\$45 copay Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay \$150 combined \$5,000 combined	\$15 copay \$35 copay \$50 copay
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 70% \$35 copay	Plan pays 70% Limited to \$250 annually combined. \$45 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice A

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	None	\$300/\$900	\$500/\$1,500
Coinsurance Out-of-Pocket Max (Individual/Family)	Not applicable	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Not Applicable	Plan pays 90%	Plan pays 70%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$10 copay \$20 copay \$20 copay Plan pays 100% Plan pays 100%	\$20 copay \$30 copay Plan pays 90% Plan pays 100% ³ Plan pays 100% ³	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 100% Plan pays 100% \$50 copay \$20 copay \$50 copay Plan pays 100%	Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$20 copay \$100 copay	\$100 copay \$40 copay \$100 copay	\$100 copay Plan pays 70% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	\$200 copay Plan pays 100%	Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$20 copay \$200 copay Plan pays 100%	\$30 copay Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70% Plan pays 70%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay Not applicable \$5,000 combined	\$15 copay \$35 copay \$50 copay Not applicable
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 50% \$20 copay	Plan pays 90% Limited to \$250 annually combined. \$30 copay	Plan pays 70% Plan pays 70%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice B

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	None	\$500/\$1,500	\$1,000/\$3,000
Coinsurance Out-of-Pocket Max (Individual/Family)	Not applicable	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Not applicable	Plan pays 80%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$15 copay \$25 copay \$25 copay Plan pays 100% Plan pays 100%	\$25 copay \$35 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 100% Plan pays 100% \$50 copay \$25 copay \$50 copay Plan pays 100%	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$30 copay \$100 copay	\$100 copay \$50 copay \$100 copay	\$100 copay Plan pays 60% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	\$200 copay Plan pays 100%	Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$25 copay \$200 copay Plan pays 100%	\$35 copay Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay Not applicable	\$15 copay \$35 copay \$50 copay Not applicable
		\$5,000 combined	
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 50% \$25 copay	Plan pays 80% Limited to \$250 annually combined. \$35 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice C

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	None	\$750/\$2,250	\$1,500/\$4,500
Coinsurance Out-of-Pocket Max (Individual/Family)	Not applicable	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Not applicable	Plan pays 80%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$25 copay \$35 copay \$35 copay Plan pays 100% Plan pays 100%	\$35 copay \$45 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 100% Plan pays 100% \$50 copay \$35 copay \$100 copay Plan pays 100%	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$50 copay \$100 copay	\$100 copay \$70 copay \$100 copay	\$100 copay Plan pays 60% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	\$300 copay Plan pays 100%	Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$35 copay \$300 copay Plan pays 100%	\$45 copay Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$15 copay \$30 copay \$45 copay Not applicable Unlimited	\$20 copay \$45 copay \$60 copay \$150 combined \$5,000 combined	\$20 copay \$45 copay \$60 copay
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 50% \$35 copay	Plan pays 80% Limited to \$250 annually combined. \$45 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice D

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$250/\$750	\$1,000/\$3,000	\$2,000/\$6,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 90%	Plan pays 80%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$20 copay \$30 copay Plan pays 90% Plan pays 100% ³ Plan pays 100% ³	\$30 copay \$40 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90%	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$40 copay \$100 copay	\$100 copay \$60 copay \$100 copay	\$100 copay Plan pays 60% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90%	Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$30 copay Plan pays 90% Plan pays 90%	\$40 copay Plan pays 80% Plan pays 80%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay \$150 combined \$5,000 combined	\$15 copay \$35 copay \$50 copay
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 90% \$30 copay	Plan pays 80% Limited to \$250 annually combined. \$40 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice E

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$500/\$1,500	\$2,000/\$6,000	\$4,000/\$12,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 90%	Plan pays 70%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$25 copay \$35 copay Plan pays 90% Plan pays 100% ³ Plan pays 100% ³	\$35 copay \$45 copay Plan pays 70% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$100 copay \$50 copay \$100 copay	\$100 copay \$70 copay \$100 copay	\$100 copay Plan pays 60% \$100 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$35 copay Plan pays 90% Plan pays 90%	\$45 copay Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay \$150 combined \$5,000 combined	\$15 copay \$35 copay \$50 copay
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 90% \$35 copay	Plan pays 70% Limited to \$250 annually combined. \$45 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice F

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$750/\$2,250	\$2,500/\$7,500	\$5,000/\$15,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$1,000/\$3,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 90%	Plan pays 70%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$30 copay \$40 copay Plan pays 90% Plan pays 100% ³ Plan pays 100% ³	\$40 copay \$60 copay Plan pays 70% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$150 copay \$60 copay \$150 copay	\$150 copay \$80 copay \$150 copay	\$150 copay Plan pays 60% \$150 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 90% Plan pays 90%	Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$40 copay Plan pays 90% Plan pays 90%	\$60 copay Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$10 copay \$20 copay \$35 copay Not applicable Unlimited	\$15 copay \$35 copay \$50 copay \$150 combined \$5,000 combined	\$15 copay \$35 copay \$50 copay
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 90% \$40 copay	Plan pays 70% Limited to \$250 annually combined. \$60 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice G

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$1,000/\$3,000	\$3,000/\$9,000	\$5,000/\$15,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$2,000/\$6,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 80%	Plan pays 70%	Plan pays 60%
Office Services			
<ul style="list-style-type: none"> ■ Primary Care ■ Speciality Care ■ Special Procedures (Cardiac Stress Tests, EMG, others) ■ Preventive Services² ■ Maternity (obstetrician/midwife) 	\$30 copay \$40 copay Plan pays 80% Plan pays 100% ³ Plan pays 100% ³	\$40 copay \$60 copay Plan pays 70% Plan pays 100% ³ Plan pays 100% ³	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Outpatient Services			
<ul style="list-style-type: none"> ■ Laboratory Services ■ Radiology Services ■ High Tech Radiology Services (MRI, CT, PET, others) ■ Physical and Occupational Therapy– 20 visits per calendar year ■ Outpatient Hospital or Surgical Facility ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80% Plan pays 80%	Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60% Plan pays 60%
Emergency Services			
<ul style="list-style-type: none"> ■ Emergency Room Visit– per visit; copay waived if admitted ■ After-Hours Urgent Care– per visit ■ Ambulance– per trip 	\$150 copay \$60 copay \$150 copay	\$150 copay \$80 copay \$150 copay	\$150 copay Plan pays 60% \$150 copay
Inpatient Services			
<ul style="list-style-type: none"> ■ Hospital (facility charge)– per admission ■ Physician and Other Professional Charges 	Plan pays 80% Plan pays 80%	Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60%
Mental Health Services			
<ul style="list-style-type: none"> ■ Outpatient Mental Health– 20 visits per calendar year ■ Inpatient Mental Health Facility– 30 days per calendar year ■ Inpatient Mental Health Professional 	\$40 copay Plan pays 80% Plan pays 80%	\$60 copay Plan pays 70% Plan pays 70%	Plan pays 60% Plan pays 60% Plan pays 60%
Pharmacy Services– 30-day supply			
<ul style="list-style-type: none"> ■ Generic Preferred Drugs ■ Brand Preferred Drugs ■ Non-Preferred Drugs ■ Brand Rx Deductible (not applicable to Generic Drugs) ■ Benefit Maximum 	\$15 copay \$30 copay \$45 copay \$100 Unlimited	\$20 copay \$45 copay \$60 copay \$200 combined \$5,000 combined	\$20 copay \$45 copay \$60 copay
Other Services			
<ul style="list-style-type: none"> ■ Durable Medical Equipment/Prosthetics and Orthotics ■ Vision Exam 	Plan pays 80% \$40 copay	Plan pays 70% Limited to \$250 annually combined. \$60 copay	Plan pays 60% Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice H

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$2,000/\$6,000	\$4,000/\$12,000	\$6,000/\$18,000
Coinsurance Out-of-Pocket Max (Individual/Family)	\$2,000/\$6,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 80%	Plan pays 70%	Plan pays 60%
Office Services			
■ Primary Care	\$30 copay	\$40 copay	Plan pays 60%
■ Speciality Care	\$40 copay	\$60 copay	Plan pays 60%
■ Special Procedures (Cardiac Stress Tests, EMG, others)	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Preventive Services ²	Plan pays 100% ³	Plan pays 100% ³	Plan pays 60%
■ Maternity (obstetrician/midwife)	Plan pays 100% ³	Plan pays 100% ³	Plan pays 60%
Outpatient Services			
■ Laboratory Services	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Radiology Services	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Physical and Occupational Therapy– 20 visits per calendar year	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Outpatient Hospital or Surgical Facility	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Physician and Other Professional Charges	Plan pays 80%	Plan pays 70%	Plan pays 60%
Emergency Services			
■ Emergency Room Visit– per visit; copay waived if admitted	\$150 copay	\$150 copay	\$150 copay
■ After-Hours Urgent Care– per visit	\$60 copay	\$80 copay	Plan pays 60%
■ Ambulance– per trip	\$150 copay	\$150 copay	\$150 copay
Inpatient Services			
■ Hospital (facility charge)– per admission	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Physician and Other Professional Charges	Plan pays 80%	Plan pays 70%	Plan pays 60%
Mental Health Services			
■ Outpatient Mental Health– 20 visits per calendar year	\$40 copay	\$60 copay	Plan pays 60%
■ Inpatient Mental Health Facility– 30 days per calendar year	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Inpatient Mental Health Professional	Plan pays 80%	Plan pays 70%	Plan pays 60%
Pharmacy Services– 30-day supply			
■ Generic Preferred Drugs	\$15 copay	\$20 copay	\$20 copay
■ Brand Preferred Drugs	\$30 copay	\$45 copay	\$45 copay
■ Non-Preferred Drugs	\$45 copay	\$60 copay	\$60 copay
■ Brand Rx Deductible (not applicable to Generic Drugs)	\$100		
■ Benefit Maximum	Unlimited	\$200 combined	
		\$5,000 combined	
Other Services			
■ Durable Medical Equipment/Prosthetics and Orthotics	Plan pays 80%	Plan pays 70%	Plan pays 60%
		Limited to \$250 annually combined.	
■ Vision Exam	\$40 copay	\$60 copay	Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

MULTI-CHOICE PLANS

Multi-Choice I

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$3,000/\$9,000	\$5,000/\$15,000	\$7,500/\$22,500
Coinsurance Out-of-Pocket Max (Individual/Family)	\$2,000/\$6,000	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 80%	Plan pays 70%	Plan pays 60%
Office Services			
■ Primary Care	\$30 copay	\$40 copay	Plan pays 60%
■ Speciality Care	\$40 copay	\$60 copay	Plan pays 60%
■ Special Procedures (Cardiac Stress Tests, EMG, others)	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Preventive Services ²	Plan pays 100% ³	Plan pays 100% ³	Plan pays 60%
■ Maternity (obstetrician/midwife)	Plan pays 100% ³	Plan pays 100% ³	Plan pays 60%
Outpatient Services			
■ Laboratory Services	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Radiology Services	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Physical and Occupational Therapy– 20 visits per calendar year	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Outpatient Hospital or Surgical Facility	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Physician and Other Professional Charges	Plan pays 80%	Plan pays 70%	Plan pays 60%
Emergency Services			
■ Emergency Room Visit– per visit; copay waived if admitted	\$150 copay	\$150 copay	\$150 copay
■ After-Hours Urgent Care– per visit	\$60 copay	\$80 copay	Plan pays 60%
■ Ambulance– per trip	\$150 copay	\$150 copay	\$150 copay
Inpatient Services			
■ Hospital (facility charge)– per admission	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Physician and Other Professional Charges	Plan pays 80%	Plan pays 70%	Plan pays 60%
Mental Health Services			
■ Outpatient Mental Health– 20 visits per calendar year	\$40 copay	\$60 copay	Plan pays 60%
■ Inpatient Mental Health Facility– 30 days per calendar year	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Inpatient Mental Health Professional	Plan pays 80%	Plan pays 70%	Plan pays 60%
Pharmacy Services– 30-day supply			
■ Generic Preferred Drugs	\$15 copay	\$20 copay	\$20 copay
■ Brand Preferred Drugs	\$30 copay	\$45 copay	\$45 copay
■ Non-Preferred Drugs	\$45 copay	\$60 copay	\$60 copay
■ Brand Rx Deductible (not applicable to Generic Drugs)	\$100	\$200 combined	
■ Benefit Maximum	Unlimited	\$5,000 combined	
Other Services			
■ Durable Medical Equipment/Prosthetics and Orthotics	Plan pays 80%	Plan pays 70%	Plan pays 60%
■ Vision Exam	\$40 copay	Limited to \$250 annually combined. \$60 copay	Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

NEW PLAN!

MULTI-CHOICE PLANS

Multi-Choice J-100

	Select Providers	PPO Providers (PHCS Network)	Non-Participating Providers
Deductible (Individual/Family)	\$200/\$600	\$500/\$1,500	\$1,000/\$3,000
Coinsurance Out-of-Pocket Max (Individual/Family)	Not applicable	\$2,000/\$6,000	\$4,000/\$12,000
Maximum Benefit while covered	Unlimited ¹	\$2,000,000 combined	
Coinsurance (after annual deductible)	Plan pays 100%	Plan pays 70%	Plan pays 60%
Office Services			
■ Primary Care	\$25 copay	\$35 copay	Plan pays 60%
■ Speciality Care	\$35 copay	\$45 copay	Plan pays 60%
■ Special Procedures (Cardiac Stress Tests, EMG, others)	Plan pays 100%	Plan pays 70%	Plan pays 60%
■ Preventive Services ²	Plan pays 100% ³	Plan pays 100% ³	Plan pays 60%
■ Maternity (obstetrician/midwife)	Plan pays 100% ³	Plan pays 100% ³	Plan pays 60%
Outpatient Services			
■ Laboratory Services	Plan pays 100%	Plan pays 70%	Plan pays 60%
■ Radiology Services	Plan pays 100%	Plan pays 70%	Plan pays 60%
■ High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 70%	Plan pays 60%
■ Physical and Occupational Therapy– 20 visits per calendar year	Plan pays 100%	Plan pays 70%	Plan pays 60%
■ Outpatient Hospital or Surgical Facility	Plan pays 100%	Plan pays 70%	Plan pays 60%
■ Physician and Other Professional Charges	Plan pays 100%	Plan pays 70%	Plan pays 60%
Emergency Services			
■ Emergency Room Visit– per visit; copay waived if admitted	\$100 copay	\$100 copay	\$100 copay
■ After-Hours Urgent Care– per visit	\$50 copay	\$70 copay	Plan pays 60%
■ Ambulance– per trip	\$100 copay	\$100 copay	\$100 copay
Inpatient Services			
■ Hospital (facility charge)– per admission	Plan pays 100%	Plan pays 70%	Plan pays 60%
■ Physician and Other Professional Charges	Plan pays 100%	Plan pays 70%	Plan pays 60%
Mental Health Services			
■ Outpatient Mental Health– 20 visits per calendar year	\$35 copay	\$45 copay	Plan pays 60%
■ Inpatient Mental Health Facility– 30 days per calendar year	Plan pays 100%	Plan pays 70%	Plan pays 60%
■ Inpatient Mental Health Professional	Plan pays 100%	Plan pays 70%	Plan pays 60%
Pharmacy Services– 30-day supply			
■ Generic Preferred Drugs	\$15 copay	\$20 copay	\$20 copay
■ Brand Preferred Drugs	\$30 copay	\$45 copay	\$45 copay
■ Non-Preferred Drugs	\$45 copay	\$60 copay	\$60 copay
■ Brand Rx Deductible (not applicable to Generic Drugs)	Not applicable	\$150 combined	
■ Benefit Maximum	Unlimited	\$5,000 combined	
Other Services			
■ Durable Medical Equipment/Prosthetics and Orthotics	Plan pays 100%	Plan pays 70%	Plan pays 60%
	Unlimited	Limited to \$250 annually combined.	
■ Vision Exam	\$35 copay	\$45 copay	Plan pays 60%

Footnotes: 1 Some benefits may have limitations.

2 Office visit copays may apply. Well-Child Visit: No charge up to age 2 for the Select Provider level; not subject to deductible up to age 5 for the PPO and Non-participating Provider levels.

3 Deductible does not apply.

CUSTOM CARE HEALTHINVESTOR (HSA) PLANS

Self-Only and Family (2+) Plan Combinations

NEW PLAN!

	PLAN A		PLAN B		PLAN C		PLAN D		PLAN E	
	Self-Only*	Family	Self-Only*	Family	Self-Only*	Family	Self-Only*	Family	Self-Only*	Family
Deductible (Individual/Family)	\$1,200*	\$2,400	\$2,850*	\$5,700	\$1,200*	\$2,400	\$2,850*	\$5,700	\$5,000*	\$10,000
Out-of-Pocket Max (Individual/Family)	\$1,200*	\$2,400	\$2,850*	\$5,700	\$3,600*	\$7,200	\$4,850*	\$9,700	\$5,000*	\$10,000
Maximum Benefit while covered	Unlimited ¹		Unlimited ¹		Unlimited ¹		Unlimited ¹		Unlimited ¹	
Coinsurance	Plan pays 100% (after annual deductible)		Plan pays 100% (after annual deductible)		Plan pays 80% (after annual deductible)		Plan pays 80 (after annual deductible)		Plan pays 100% (after annual deductible)	
Preventive visits	\$25 copay									
All other covered services	Subject to Annual Deductible and Coinsurance									

* The deductible and out-of-pocket maximum apply to self-only plans; not applicable for individuals covered under family plans.

This is a summary description and is not intended to replace the *Group Agreement*, *Group Policy*, and/or *Evidence of Coverage*, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions. Benefits subject to Department of Insurance approval.

For Multi-Choice Plans, Select Provider coverage is provided by Kaiser Foundation Health Plan of Georgia, Inc. PPO and Non-participating Provider coverages are underwritten by Kaiser Permanente Insurance Company (KPIC). Provider options and benefit levels are described in the Kaiser Permanente Multi-Choice brochure and the *Evidence of Coverage*.

Important information: Written information on topics related to coverage offered to employer groups in the small group market can be obtained by calling **404-364-7105**. Topics include:

- 1) Factors that affect rate setting and rate adjustments.
- 2) Provisions related to renewing coverage.
- 3) Plan designs and premiums available to small groups.

Note: Kaiser Permanente group plans do not include a pre-existing condition clause.

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