

Choosing The Right Plan For You

PPO – Plans A, B, C & D

Plans A through D are considered Participating Provider Organization (PPO) plans which allow the choice to see any provider, but pays the highest level of benefits when you use a participating provider. All plans offer you a variety of Calendar Year Deductibles and Out-of-Pocket maximums. Plan A has copayments for office visits and exams.

HSA Plan – Plan H

Plan H is a Health Savings Account (HSA) plan, allowing you the opportunity to save and invest in your health care future. This policy is a qualified HSA, high-deductible plan that allows you to contribute to an HSA tax deductible account. HSA Plans also utilize the Participating Provider Organization (PPO) allowing you the choice to see any provider, but pays the highest level of benefits when you use a participating provider.

	Plan A		Plan B		Plan C		Plan D		Plan H		
	DEDUCTIBLE INDIVIDUAL - FAMILY	OOP MAXIMUM	DEDUCTIBLE INDIVIDUAL - FAMILY	OOP MAXIMUM	DEDUCTIBLE INDIVIDUAL - FAMILY	OOP MAXIMUM	DEDUCTIBLE INDIVIDUAL - FAMILY	OOP MAXIMUM	DEDUCTIBLE INDIVIDUAL - FAMILY	OOP MAXIMUM	
Benefits All benefits are subject to the deductible being met prior to payment by Preferred Health, unless otherwise stated.	\$500 - 1,500	\$3,000	\$1,000 - 3,000	\$5,000	\$1,000 - 3,000	\$5,000	\$1,000 - 3,000	\$5,000	Note: The individual deductible applies only if policyholder enrolls without dependents. If the policyholder and one or more dependents enroll, only the family deductible applies.	\$1,000 - 2,000	\$3,000 - 6,000
	\$1,000 - 3,000	\$5,000	\$2,500 - 7,500	\$7,500	\$2,500 - 7,500	\$7,500	\$2,500 - 7,500	\$7,500			
	\$2,500 - 7,500	\$5,000	\$5,000 - 15,000	\$10,000	\$5,000 - 15,000	\$10,000	\$5,000 - 15,000	\$10,000			
	\$5,000 - 15,000	\$5,000	\$7,500 - 22,500	\$12,500	\$7,500 - 22,500	\$12,500	\$7,500 - 22,500	\$12,500			
			\$10,000 - 30,000	\$15,000	\$10,000 - 30,000	\$15,000	\$10,000 - 30,000	\$15,000			
Lifetime Maximum:	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000		
PREVENTATIVE/ROUTINE SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	
Routine Physical Exams	\$25 Copay † then 100% *	\$25 Copay † then 60% *	80% *	60% *	70% *	50% *	Not Covered		80% *	50% *	
Well-Baby Care											
Routine Immunizations/Vaccinations	80% † *	60% † *									
Women's Annual Exams	\$25 Copay † then 100% *	\$25 Copay † then 60% *	80% *	60% *	70% *	50% *	75% *	50% *	80% *	50% *	
Routine Mammograms	80% † *	60% † *									
PHYSICIAN/PROVIDER SERVICES											
Office Visits & Urgent Care Facilities	\$25 Copay † then 100%	\$25 Copay † then 60%	80%	60%	70%	50%	75%	50%	80%	50%	
Surgery	80%	60%									
Alternative Care (Chiropractic, Acupuncture or Naturopathic Services)	\$25 Copay † then 80% to \$1,000 CYM		80% to \$1,000 CYM		70% to \$1,000 CYM		Not Covered		80% to \$1,000 CYM		
HOSPITAL SERVICES											
Inpatient Room & Board	80%	60%	80%	60%	70%	50%	75%	50%	80%	50%	
Outpatient Surgery											
OUTPATIENT SERVICES											
Outpatient Hospital/Facility											
Lab, X-Ray, CT Scan, MRI	80%	60%	80%	60%	70%	50%	75%	50%	80%	50%	
Emergency Room, \$100 Copay per visit											
OTHER COVERED SERVICES											
Prescription Drugs	50% to \$5,000 CYM (see benefit options)		50% to \$5,000 CYM (see benefit options)		50% to \$5,000 CYM (see benefit options)		50% to \$5,000 CYM (see benefit options)		80%		
Accidental Injury – Medical (within 90 days of injury)	80% with Ded waived for 1st \$500 only	60% with Ded waived for 1st \$500 only	80% with Ded waived for 1st \$500 only	60% with Ded waived for 1st \$500 only	70% with Ded waived for 1st \$500 only	50% with Ded waived for 1st \$500 only	75%	50%	80%	50%	
Accidental Injury – Dental (within 365 days of injury)	80% with Ded waived, maximum of \$500		80% with Ded waived, maximum of \$500		70% with Ded waived, maximum of \$500		Not Covered		Not Covered		
Ambulance	80% to \$5,000 CYM		80% to \$5,000 CYM		70% to \$5,000 CYM		75% to \$5,000 CYM		80% to \$5,000 CYM		
Allergy Injections											
Durable Medical Equipment (5,000 CYM)											
Home Health (130 visits or \$10,000 CYM)											
Inpatient Mental Benefits (\$1,500 CYM)											
Inpatient Rehabilitation (60 days CYM)	80%	60%	80%	60%	70%	50%	75%	50%	80%	50%	
Maternity											
Outpatient Rehabilitation (\$2,500 CYM)											
Skilled Nursing Facility (100 days CYM)											
Transplant Services (Lifetime Maximum of \$250,000)	100%	Lesser of 50% billed amount or \$250,000	100%	Lesser of 50% billed amount or \$250,000	100%	Lesser of 50% billed amount or \$250,000	100%	Lesser of 50% billed amount or \$250,000	100%	Lesser of 50% billed amount or \$250,000	

† Deductible Waived

* Combined Calendar Year Maximum of \$125

Copay = The dollar amount or percentage of the covered service that you are responsible for paying.

CYM = Calendar Year Maximum

DED = Deductible

OOP = Out-of-Pocket