



Plan Name:	PPO 750	
Annual Deductible, Out-of Pocket and Lifetime Benefit Maximums	In Network	Out of Network
Annual Deductible (Single/Family)	\$750/\$2,250	\$1,500/\$4,500
Out-of-pocket Annual Maximum (Single/Family) Includes deductible	\$2,000/\$6,000	No Limit
Plan Coinsurance (After Annual Deductible)	80%	60%
Lifetime Transplant Benefit Maximum	\$1,000,000	
Lifetime Non-Transplant Benefit Maximum	\$2,000,000	

Benefit Limits	
Allergy Testing Lifetime Limit	Once Per Lifetime
DME & Prosthetics Combined Annual Maximum	\$2,000
Home Health Services Annual Limit	30 Visits
Infertility Diagnosis Lifetime Maximum	\$1,000
Inpatient Mental Health and Substance Abuse Combined Annual Limit	20 Days
Outpatient Rehabilitative Services Annual Limit	30 Visits
Preventative Health Services Annual Limit	1 Visit
Routine Gynecological Exam Annual Limit	1 Exam
Skilled Nursing Facility & Inpatient Rehabilitation Services Combined Annual Limit	30 Days
TMJ Benefit Annual Maximum	\$500

Co-payments/Co-Insurance Sharing		
Allergy Care	*\$30/Visit	60% Co-insurance
Ambulance (Life Threatening Emergency Only)	80% Co-insurance	60% Co-insurance
CAT Scan and MRI	80% Co-insurance	60% Co-insurance
DME & Prosthetics	80% Co-insurance	60% Co-insurance
Emergency Room (Co-payment Waived if Admitted)	*\$250	*\$250
Home Health Visits	80% Co-insurance	60% Co-insurance
Inpatient Hospital Care	80% Co-insurance	60% Co-insurance
Inpatient Lab, X-Ray, and other Diagnostic Services	80% Co-insurance	60% Co-insurance
Inpatient Mental Health	*\$100/Day	60% Co-insurance
Inpatient Rehabilitation	80% Co-insurance	60% Co-insurance
Inpatient Substance Abuse	*\$100/Day	60% Co-insurance
Maternity Care- Obstetric Office Visits & Delivery (available only with Family Coverage)	80% Co-insurance	60% Co-insurance
Newborn Care in the Hospital	80% Co-insurance	60% Co-insurance
Non-Inpatient Lab	80% Co-insurance	60% Co-insurance
Outpatient and Freestanding Radiology (excluding CAT Scan and MRI)	80% Co-insurance	60% Co-insurance
Outpatient Dialysis	80% Co-insurance	60% Co-insurance
Outpatient Rehabilitative Services	80% Co-insurance	60% Co-insurance
Outpatient Surgery	80% Co-insurance	60% Co-insurance
Preventive Health Service	*\$30/Visit	60% Co-insurance
Well Child Services (Through Age 5)	*\$30/Visit	*\$30/Visit
Primary Care Physician Office Visit	*\$30/Visit	60% Co-insurance
Routine Gynecological Exam	*\$30/Visit	60% Co-insurance
Skilled Nursing Facility/Inpatient Rehabilitation	80% Co-insurance	60% Co-insurance
Specialist Office Visit	*\$30/Visit	60% Co-insurance
Urgent Care	80% Co-insurance	60% Co-insurance

Waiting Period for Pre-existing	12 Months
Maternity Benefit Waiting Period (available only with Family Coverage)	12 Months

Prescription Drugs	
Calendar Year Prescription Drug Deductible, Per Member	\$200
Generic	\$10 copay after annual rx deductible
Brand-Formulary	\$25 copay after annual rx deductible
Brand-Non-Formulary	\$50 copay after annual rx deductible

*Co-payments do not apply to deductible or Out of Pocket Maximum