

Plan Name	Local PPO	NPPO
Calendar Year Deductible	\$400	\$400
Annual Out of Pocket	\$3,400 - Combined In and Out of Network	\$3,500
Office Services		
PCP Office Visit	\$25 copay	\$10 copay
Specialist Office visit	\$50 copay	\$30 copay
Preventive Care Services	\$0	\$0
Medicare-covered Specialists		
Chiropractic Visit	20%	\$20 copay
Podiatry Visit	\$50 copay	\$30 copay
Eye Exam	\$50 copay	\$30 copay
Hospital / Facility Services		
In-Patient Hospital Care	\$200 copayment per day (days 1-5)	\$250 copayment per day (days 1-5)
Skilled Nursing Facility Care (100 day max)	\$0 (days 1-20); 20% per day (days 21-100); Plan pays \$0 after 100 days	\$0 (days 1-20); \$75 copay per day (days 21-100); Plan pays \$0 after 100 days
In-Patient Mental Health	\$200 copayment per day (days 1-5). 190 days lifetime limit in a psychiatric facility	\$250 copayment per day (days 1-5). 190 days lifetime limit in a psychiatric facility
Outpatient Services		
Out-Patient Hospital / Surgical Facility	20%	10%
Physical/Speech/Occupational Therapy	20%	\$30 copay
Clinical Lab / Outpatient X-Ray	10%	\$20 copay
Ambulance Services	\$150 copay per date of service	\$100 copay per date of service
Emergency Care (waived if admitted)	\$65 copay	\$50 copay
Urgent Care	\$50 copay	\$35 copay
Pharmacy		
Annual Deductible	N/A	N/A
Generic [Preferred / Non-Preferred]	\$10	\$15
Brand Name [Preferred / Non-Preferred]	\$20 / \$45	\$25 / \$45
Specialty [high cost / unique]	\$95	25%
Medicare Part B	\$0	\$0
Mail Order - 90 day supply	2 x copay	2 x copay
Additional Services		
Hearing Services	\$500 allowance / 36 months + Annual Exam	\$500 allowance / 36 months + Annual Exam
Eyewear / Contact lenses	\$100 eyewear allowance + Annual Exam	\$100 eyewear allowance + Annual Exam
Healthcare Agency - home care visits	\$0	\$0
Durable Medical Equipment	20%	20%
Diabetic/ Medical Supplies	20%	20%
2027 Premium	\$107.51	\$65.77