



<b>PPO Provider Network:</b>
First Health as primary with a Multiplan Network as secondary
<b>Out-of-Network Providers:</b>
Not Covered
<b>Facilities:</b>
Not Covered

Rates	Elite MEC	Visit MEC	Premium MEC
Individual	\$153.62	\$235.93	\$357.98
Employee + Child	\$203.63	\$300.66	\$460.93
Employee + Spouse	\$219.23	\$328.73	\$508.33
Employee + Family	\$270.77	\$405.29	\$582.75

	ELITE MEC	MEC VISIT	PREMIUM HEALTH
Deductible	\$0 Individual / \$0 Family	\$0 Individual / \$0 Family	\$0 Individual / \$0 Family
Out-of-Pocket Max	N/A	N/A	N/A
Preventative & Wellness Office Visits	✓ \$0 Copay	✓ \$0 Copay	✓ \$0 Copay
Telemedicine	✓ \$0 Consult Fee	✓ \$0 Consult Fee	✓ \$0 Consult Fee
Primary Care Office Visit		✓ \$25 Copay (2 visits)	✓ \$35 Copay
Specialist Office Visit		✓ \$75 Copay (1 panel/test)	✓ \$75 Copay
Laboratory Services		✓ \$50 Copay (1 per visit)	✓ \$150 Copay
Radiology			✓ \$65 Copay
Imaging (CT/MRI/MRA/PET Scans)			✓ \$600 Copay/image (limit 3)
Urgent Care			✓ \$85 Copay
Emergency Room Services			
Hospital Inpatient Room & Board			
Preventative Prescriptions (Generic)	✓ \$0 Copay	✓ \$0 Copay	✓ \$0 Copay
Preferred Prescription Drugs (amount shown or less)		✓ Tier 1 = \$0; Tier 2 = \$10 Tier 3 = \$25; Tier 4 = \$50	✓ Tier 1 = \$0; Tier 2 = \$10 Tier 3 = \$25; Tier 4 = \$50
Inpatient Hospitalization & Surgery			
Outpatient or Free-Standing Facility			
Treatment: Chemical Abuse/Dependency			
Home Health Care			
Pregnancy Benefits			

✓ Included in Plan

\*After deductible

Disclaimer: If plan comparison differs from the Schedule of Benefits, the Schedule of Benefits will govern. Refer to the Schedule of Benefits for a list of Benefits Coverage, Limitations, and Exclusions.



<b>PPO Provider Network:</b>
PHCS Practitioner & Ancillary
<b>Out-of-Network Providers:</b>
Not Covered
<b>Facilities (Reference Based Pricing):</b>
**140% of Medicare Allowable Amount

Rates	Basic	Pro
Individual	\$614.16	\$743.23
Employee + Child	\$818.65	\$941.25
Employee + Spouse	\$938.55	\$1085.36
Employee + Family	\$1187.20	\$1382.43

	BASIC	PRO
Deductible	✓ \$250 Individual / \$500 Family	✓ \$0 Individual / \$0 Family
Out-of-Pocket Max	✓ \$7,500 Individual / \$15,000 Family	✓ \$4,000 Individual / \$8,000 Family
Preventative & Wellness Office Visits	✓ \$0 Copay	✓ \$0 Copay
Telemedicine	✓ \$0 Consult Fee	✓ \$0 Consult Fee
Primary Care Office Visit	✓ \$20 Copay	✓ \$10 Copay
Specialist Office Visit	✓ \$40 Copay (Limit 8/year)*	✓ \$20 Copay (Limit 10/year)
Laboratory Services	✓ \$50 Copay (Limit 3/year)*	✓ \$50 Copay (Limit 3/year)
Radiology	✓ \$350 Copay/image (Limit 1/year)*	✓ \$350 Copay/image (Limit 2/year)
Imaging (CT/MRI/MRA/PET Scans)		
Urgent Care	✓ \$40 Copay	✓ \$40 Copay
Emergency Room Services	✓ \$350 Copay + 50% Coins (Limit 1/year)*	✓ \$350 Copay + 50% Coins (Limit 1/year)
Inpatient Hospitalization	✓ \$350 Copay (Limit 7 days/year)*	✓ \$350 Copay (Limit 9 days/year)
Preventative Prescriptions (Generic)	✓ \$0 Copay	✓ \$0 Copay
Preferred Prescription Drugs (amount shown or less)	✓ Tier 1 = \$0; Tier 2 = \$10; Tier 3 = \$25; Tier 4 = \$50	✓ Tier 1 = \$0; Tier 2 = \$10; Tier 3 = \$25; Tier 4 = \$50
Inpatient Surgery	✓ \$350 Copay + 20% Coins (Limit 2 surgeries/year)*^	✓ \$350 Copay + 20% Coins (Limit 3 surgeries/year)^
Outpatient or Free-Standing Facility	✓ \$350 Copay + 20% Coins (Limit 1 surgery/year)*^	✓ \$350 Copay + 20% Coins (Limit 1 surgery/year)^
Treatment: Chemical Abuse/Dependency	✓ Outpatient: \$350 Copay (1 admission/year)*^ Inpatient: \$350 Copay/admission (Limit 7 days)*^; (See plan documents; Precertification required)	✓ Outpatient: \$350 Copay (1 admission/year)^ Inpatient: \$350 Copay/admission (Limit 9 days)^; (See plan documents; Precertification required)
Home Health Care	✓ \$25 Copay (Limit 10/year)*	✓ \$20 Copay (Limit 10/year)
Pregnancy Benefits		✓ \$350 Copay + 50% Coins (Childbirth/Delivery)^ \$350 Copay (Professional Services)^

✓ Included in Plan

\*After deductible; then plan pays 100% of the PPO Amount or Allowed Amount.

^Subject to a 12 month waiting period.

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