



Plan Options	<u>\$500 Ded PPO</u> 100/80/80/50/\$25	<u>\$750 Ded PPO</u> <u>\$1,000 Ded PPO</u> <u>\$1,500 Ded PPO</u> <u>\$2,000 Ded PPO</u> <u>\$2,500 Ded PPO</u> 100/80/80/50/\$30	ANH Plan HSA HSA Qualified PPO 80/80/60
Deductible (Individual/Family) per cal. year	<u>\$500 Ded PPO</u> (\$500 / \$1,500)	<u>\$750 Ded PPO</u> (\$750 / \$2,250) <u>\$1,000 Ded PPO</u> (\$1,000 / \$3,000) <u>\$1,500 Ded PPO</u> (\$1,500 / \$4,500) <u>\$2,000 Ded PPO</u> (\$2,000 / \$6,000) <u>\$2,500 Ded PPO</u> (\$2,500 / \$7,500)	(\$1,500/\$3,000)
Out-of-pocket maximum (Individual/Family) Per cal. year	\$3,500 / \$10,500	\$3,500 / \$10,500	\$5,000 / \$10,000 (Ded Included)
Copay Per office visit (PPO plans)	\$25 copay	\$30 copay	N/A
Office visit copay applies for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department. Copay does not apply for surgery, radiation and chemotherapy, spinal manipulations or if Member directly admitted to hospital. Copay does not count toward any annual deductible or stoploss.			
Plan Benefits			
Professional Services	Preferred / Participating	Preferred / Participating	Preferred / Participating
Office Visit	100% / 50% (Not subject to the deductible)	100% / 50% (Not subject to the deductible)	80% / 60% Deductible Applies
Outpatient Diagnostic Lab & X-ray	100% / 50% (Not subject to the deductible) First \$500 per cal. year 80% / 50% (Subject to the deductible) Charges above \$500 per cal. year	100% / 50% (Not subject to the deductible) First \$500 per cal. year 80% / 50% (Subject to the deductible) Charges above \$500 per cal. year	80% / 60% Deductible Applies
Hospital Facility			
Inpatient Care (including inpatient and outpatient Diagnostic Lab & X-ray)	80% / 50%	80% / 50%	80% / 60% Deductible Applies
Ambulatory Surgery Centers	80% / 50%	80% / 50%	80% / 60%
Skilled Nursing Facility (90 day maximum)	80%	80%	80%
Emergency Room (Waived if admitted)	80% / 50% \$150 Copay	80% / 50% \$150 Copay	80% / 60% No ER Copay
Vision Care- Optional Benefit	(Deductible and office visit copay does not apply to exam or hardware option.)		
Vision Exam	One Eye Exam 100%	One Eye Exam 100%	One Eye Exam 100%
Hardware Benefit	80% to \$200 hardware max every 2 years, hardware not subject to stoploss.		
Preventive Care			
Annual Exam, well baby care, immunizations & cancer screening (Copay applies / not subject to the deductible)	100% / 50%, unlimited max	100% / 50%, unlimited max	80% / 60% unlimited max

Other Services			
Transplants \$250,000 lifetime maximum \$50,000 per transplant donor organ procurement maximum \$2,500 per transplant travel & lodging	80% / 50%	80% / 50%	80% / 60% \$250,000 lifetime maximum
Mental Disorders 8 Inpatient days per calendar Year 12 Outpatient visits per calendar year**	80% / 50%	80% / 50%	80% / 60%
Chemical Dependency – \$14,000 maximum every two years	80% / 50%	80% / 50%	80% / 60%
Rehabilitation \$30,000 per condition inpatient maximum \$1,500 per year outpatient maximum**	Inpatient 80% / 50% Outpatient 80% / 50%	Inpatient 80% / 50% Outpatient 80%/50%	Inpatient 80% / 60% Outpatient 80% / 60%
Neurodevelopmental Therapy** For Children age 6 & under \$1,500 per cal. year maximum	80% / 50%	80% / 50%	80% / 60%
Home Health Care & Hospice Care 130 home health visits per cal. year max. 6 mo. hospice max.	80% / 80%	80% / 80%	80% / 80%
Spinal Manipulations – 10 manipulation limit per cal. year max.	80% / 50%	80% / 50%	80% / 60%
Acupuncture – 12 visits per cal. year max.	80% / 50%	80% / 50%	80% / 60%
Prescription Drug (Generic / Brand Name / Non-formulary Copay)			
Retail - Mail Order	\$500 Ded PPO, \$750 Ded PPO, \$1000 Ded PPO, \$1500 Ded PPO, \$2000 Ded PPO, and \$2500 Ded PPO: \$10/\$35/\$70 - \$20/\$70/\$140		
	HSA (Participating only) 80%		
Regence Life and Health	Minimum \$10,000 Employee Life and AD&D Benefit, Optional \$15,000 and \$25,000 Employee Life AD&D also available		
AssistNET	Employee Assistance Program, Free and Confidential		
CareEnhance - Special Beginnings	24hr nurse line - Wellness program for pregnant women. Added at no additional charge		
Lifetime Maximum	\$2,000,000		
** Benefits do not apply to the out of pocket coinsurance amount No 4 th Quarter Deductible Carryover. This is a brief summary of benefits. For full coverage provisions, including a description of waiting periods, limitations, & exclusions, refer to the benefit brochure.			