

Benefits Summary – Red, Blue and White Plans

Plan Benefits*	Red (PPO)		Blue (EPO)	White (PPO)	
	In-Network	Out-of-Network <sup>1</sup>	In-Network ONLY (EPO)	In-Network	Out-of-Network <sup>1</sup>
<b>Deductible</b> <b>Coinsurance</b> (what you pay) <b>Out-of-Pocket Maximum</b> (includes deductible, coinsurance and co-pays)	\$500 Single / \$1,000 Family 20% \$4,000 Single / \$8,000 Family	\$1,000 Single / \$2,000 Family 40% \$8,000 Single / \$16,000 Family	\$600 Single / \$1,200 Family 20% \$4,000 Single / \$8,000 Family	\$1,200 Single / \$2,400 Family 30% \$4,000 Single / \$8,000 Family	\$2,400 Single / \$4,800 Family 50% \$8,000 Single / \$16,000 Family
<b>Income-Based Health Reimbursement Account</b> (if eligible)	\$1,000 Single / \$2,000 Family		\$1,000 Single / \$2,000 Family	\$1,000 Single / \$2,000 Family	
<b>Primary Care Office Visits</b> <b>Specialist Office Visits</b>	\$30 co-pay \$40 co-pay	40% 40%	\$40 co-pay \$50 co-pay	\$40 co-pay \$50 co-pay	50%/50% 50%/50%
<b>Telemedicine — Teladoc</b> Urgent Care Behavioral Health Nemours App (children only)	\$25 co-pay \$30 co-pay \$15 co-pay	Not Covered	\$35 co-pay \$40 co-pay \$15 co-pay	\$35 co-pay \$40 co-pay \$15 co-pay	Not Covered
<b>Wellness/Routine Care</b> Physical Exams/Vision Exam Well-Child Care Routine & Diagnostic Mammograms	0%	40%	0%	0%	50%
<b>Diagnostic X-Ray &amp; Lab Services</b> Inpatient or Outpatient	20%	40%	20%	30%	50%
<b>Hospital Benefits, Surgical Benefits</b> Inpatient or Outpatient	20%	40%	20%	30%	50%
<b>Emergency Room</b> (co-pay waived, if admitted) <b>Urgent Care Center</b> <b>Ambulance Services</b>	\$250 co-pay \$50 co-pay \$50 co-pay	\$250 co-pay \$50 co-pay \$50 co-pay	\$250 co-pay \$50 co-pay \$50 co-pay	\$250 co-pay \$50 co-pay \$50 co-pay	\$250 co-pay \$50 co-pay \$50 co-pay
<b>Mental Health/Substance Abuse</b> Inpatient, Partial Hospital and Intensive Outpatient Care Office Visits	20% \$30 co-pay	40% 40%	20% \$40 co-pay	30% \$40 co-pay	50% 50%
<b>Chiropractic</b> (30 days maximum per calendar year)	\$40 co-pay	40%	\$50 co-pay	\$50 co-pay	50%
<b>Short-term Rehab</b> Physical, Speech, Occupational, Cardiac or Cognitive Therapy	\$40 co-pay	40%	\$50 co-pay	\$50 co-pay	50%
<b>Other Benefits:</b> Fertility Benefits (2 cycles per year) Maternity Support Type 2 Diabetes Management Centers of Excellence (certain surgeries) Virtual Physical Therapy 2nd Opinion	20% 0% 0% 0% 0% 0%	Not Covered	20% 0% 0% 0% 0% 0%	30% 0% 0% 0% 0% 0%	Not Covered
<b>Prescription Drug</b> Generic  Rx Preferred Brand  Rx Non-Preferred Brand  Rx Maintenance Medications (90-day supply)	\$10 co-pay  20% (min. \$30, max. \$60)  40% (min. \$60, max. \$120)  2.5 x co-pay or coinsurance 2.0 x co-pay or coinsurance (Nemours Onsite Pharmacy)	Not Covered	\$10 co-pay  20% (min. \$30, max. \$60)  40% (min. \$60, max. \$120)  2.5 x co-pay or coinsurance 2.0 x co-pay or coinsurance (Nemours Onsite Pharmacy)	\$10 co-pay  20% (min. \$30, max. \$60)  40% (min. \$60, max. \$120)  2.5 x co-pay or coinsurance 2.0 x co-pay or coinsurance (Nemours Onsite Pharmacy)	Not Covered
<b>Prescription Drug Specialty**</b>	20% (min. \$100, max. \$200)	Not Covered	20% (min. \$100, max. \$200)	20% (min. \$100, max. \$200)	Not Covered

\*Percentages indicate what you pay  
<sup>1</sup> All out-of-network benefits are subject to balance billing. If there is a discrepancy between the information here and the plan document, the plan document governs.  
This chart does not describe all plan exclusions or limitations. **For services shown above with coinsurance, this is applied after the deductible. The only exception is with the prescription plans.**

\*\*Specialty medications included on the SaveOnSP drug list may be filled through the SaveOnSP program at significant cost savings to you. Please note that manufacturer assistance for the drugs on the SaveOnSP list requires program enrollment and will not be used to satisfy the deductible and out-of-pocket maximum