Benefits Summary – Medical Plans

Plan Benefits*	High PPO (previously the Red Plan)		EPO (previously the Blue Plan)	Mid PPO (previously the White Plan)		Low PPO with HSA** (previously the Green Plan)	
	In-Network	Out-of-Network[1]	In-Network ONLY (EPO)	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible with Nemours Pediatrics **Deductible** **Coinsurance** (what you pay) **Out-of-Pocket Maximum** (includes deductible, coinsurance and co-pays)	$250 per child $500 Individual / $1,000 Family 20% $4,000 Individual / $8,000 Family	Non Applicable $1,000 Individual / $2,000 Family 40% $8,000 Individual / $16,000 Family	$300 per child $600 Individual / $1,200 Family 20% $4,000 Individual / $8,000 Family	$600 per child $1,200 Individual / $2,400 Family 30% $4,000 Individual / $8,000 Family	Non Applicable $2,400 Individual / $4,800 Family 50% $8,000 Individual / $16,000 Family	$1,700 per child $2,500 Individual / $5,000 Family 20% $5,000 Individual / $10,000 Family	Non Applicable $5,000 Individual / $10,000 Family 50% $10,000 Individual / $20,000 Family
Income-Based Health Reimbursement Account (if eligible)	$1,000 Individual / $2,000 Family		$1,000 Individual / $2,000 Family	$1,000 Individual / $2,000 Family		Non Applicable	
Employer HSA Funding	Non Applicable		Non Applicable	Non Applicable		$250 Individual / $500 Family	
Nemours Primary Care Office Visits **Nemours Specialist Office Visits** **Primary Care Office Visits** **Specialist Office Visits**	$0 co-pay $0 co-pay $30 co-pay $40 co-pay	Non Applicable Non Applicable 40% 40%	$0 co-pay $0 co-pay $40 co-pay $50 co-pay	$0 co-pay $0 co-pay $40 co-pay $50 co-pay	Non Applicable Non Applicable 50% 50%	20% after deductible	50% after deductible
Telemedicine Urgent Care - Teladoc Behavioral Health - Teladoc Nemours Children's MyChart app	$0 co-pay $30 co-pay $0 co-pay	Not Covered	$0 co-pay $40 co-pay $0 co-pay	$0 co-pay $40 copay $0 co-pay	Not Covered	0% 20% after deductible 0%	Not Covered
Wellness/Routine Care Physical Exams/Vision Exam Well-Child Care Routine & Diagnostic Mammograms	0%	40%	0%	0%	50%	0%	50% after deductible
Diagnostic X-Ray & Lab Services	20%	40%	20%	30%	50%	20% after deductible	50% after deductible
Hospital Benefits, Surgical Benefits Inpatient or Outpatient	20%	40%	20%	30%	50%	20% after deductible	50% after deductible
Emergency Room (co-pay waived, if admitted) **Urgent Care Center** **Ambulance Services**	$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	20% after deductible 20% after deductible 20% after deductible	20% after deductible 50% after deductible 50% after deductible
Mental Health/Substance Abuse Nemours Pediatrics Outpatient Care Office Visits Inpatient, Partial Hospital and Intensive Outpatient Care Office Visits	$0 co-pay 20% $30 co-pay	Non Applicable 40% 40%	$0 co-pay 20% $40 co-pay	$0 co-pay 30% $40 co-pay	Non Applicable 50% 50%	20% after deductible	50% after deductible
Chiropractic (30 days max. per calendar year)	$40 co-pay	40%	$50 co-pay	$50 co-pay	50%	20% after deductible	50% after deductible
Short-term Rehab Physical, Speech, Occupational, Cardiac or Cognitive Therapy	$40 co-pay	40%	$50 co-pay	$50 co-pay	50%	20% after deductible	50% after deductible
Other Benefits: Fertility Benefits (2 Smart Cycles per family per lifetime) Maternity Support Type 2 Diabetes Management Centers of Excellence (certain surgeries) Weight Management Virtual Physical Therapy 2nd Opinion	20% 0% 0% 0% 0% 0% 0%	Not Covered	20% 0% 0% 0% 0% 0% 0%	30% 0% 0% 0% 0% 0% 0%	Not Covered	20% after deductible 0% 0% 0% after $1,700 Individual / $3,400 Family 0% 0% 0%	Not Covered
Prescription Drug 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	20% after deductible $10 co-pay for non-ACA preventive generic 100% for ACA preventive generic	Not Covered
Prescription Drug Specialty**	20% (min. $100, max. $200)	Not Covered	20% (min. $100, max. $200)	20% (min. $100, max. $200)	Not Covered	20% after deductible	Not Covered

*Percentages indicate what you pay **If more than one person is covered in the Low Plan with HSA, the full family deductible must be met before benefits are paid.

[1] 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