

## Consumer Driven Health Plan (CDHP)

	Consumer Driven Health Plan		Additional Benefits	
<b>Calendar Year Deductible (CYD)- (When Applicable)</b>				
	<b>In Network</b>	<b>Out of Network</b>	<b>Health Center</b>	<b>Max HRA \$</b>
Individual	\$2,500	\$5,000	\$0.00	\$600
2 Member Family	\$5,000	\$10,000	\$0.00	\$1,200
3 or More Member Family	\$7,500	\$15,000	\$0.00	\$1,200
<b>Coinsurance- (When Applicable)</b>				
	<b>In Network</b>	<b>Out of Network</b>	<b>Health Center</b>	<b>HRA \$ funded</b>
Plan Reimbursement	80%	60%	100%	100%
Member Responsibility	20%	40%	\$0.00	\$0.00
<b>Maximum Out of Pocket</b>				
	<b>In Network</b>	<b>Out of Network</b>	<b>Health Center</b>	<b>HRA \$</b>
Individual	\$6,500	\$90,000	\$0.00	applicable for use
2 Member Family	\$10,500	\$90,000	\$0.00	applicable for use
3 or More Member Family	\$13,200	\$90,000	\$0.00	applicable for use
What Applies to the Out-of-Pocket Max	Deductibles, Coinsurance, Copays & Rx		No Max	N/A
<b>Physician Office Visits</b>				
	<b>In Network</b>	<b>Out of Network**</b>	<b>Health Center</b>	<b>HRA \$</b>
Primary Care Physician (PCP)	\$20 Copay	40% After CYD	\$0.00	applicable for use
Specialists (No Referral Required)	\$35 (CCN)/\$50 (Non-CCN)	40% After CYD	\$0.00	applicable for use
<b>Diagnostic Services</b>				
	<b>In Network</b>	<b>Out of Network**</b>	<b>Health Center</b>	<b>HRA \$</b>
Clinical Lab (Blood Work) at Independent	20% After CYD	40% After CYD	\$0.00	applicable for use
X-rays at Independent Facility	20% After CYD	40% After CYD	\$0 w/referral	applicable for use
Advanced Imaging (MRI, PET, CAT, MRA)	20% After CYD	40% After CYD	\$0 w/referral	applicable for use
<b>Hospital Services</b>				
	<b>In Network</b>	<b>Out of Network**</b>	<b>Health Center</b>	<b>HRA \$</b>
Inpatient Hospital	20% After CYD	40% After CYD	N/A	applicable for use
Outpatient Hospital	20% After CYD	40% After CYD	N/A	applicable for use
Physician Services at Outpatient Hospital	20% After CYD	40% After CYD	N/A	applicable for use
Emergency Room (Waived If Admitted)	\$250 Copay		N/A	applicable for use
Urgent Care Facility	\$75 Copay		\$0.00	applicable for use
<b>Mental Health / Alcohol &amp; Substance Abuse</b>				
	<b>In Network</b>	<b>Out of Network**</b>	<b>Health Center</b>	<b>HRA \$</b>
Inpatient	20% After CYD	40% After CYD	N/A	applicable for use
Outpatient Facility	No Charge	40% After CYD	Behavior Spec Availa	applicable for use
Physician Office Visit	\$35 (CCN)/\$50 (Non-CCN)	40% After CYD	Behavior Spec Availa	applicable for use
<b>Prescription Drugs (Rx)</b>				
	<b>In Network</b>	<b>Out of Network**</b>	<b>Health Center</b>	<b>HRA \$</b>
Tier 1 - Generic	\$5 Copay	Not Covered	\$0.00	applicable for use
Tier 2 - Preferred Brand Name	\$35 Copay		\$0 if available	applicable for use
Tier 3 - Non-Preferred Brand Name	\$70 Copay		\$0 if available	applicable for use
Tier 4 - Speciality Drugs/Self Inject.	\$250 Copay		Not applicable	applicable for use
Mail-Order Program (90 Day supply)	2.5x Retail Copay		\$0.00	applicable for use

Calendar Year Deductible (CYD) must be met before any co-insurance applies.

**\*\*Out-Of-Network Balance Billing**

For information regarding out-of network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-Of-Network Benefits section on the Summary of Benefits and Coverage (SBC).



