Passport Plan Summary

Deductible, coinsurance and copay represent WHAT YOU PAY. Benefits apply after calendar year deductible is met, unless otherwise noted as "no deductible," "copay" or "covered in full."

IN = In-network **OUT** = Out-of-network	OPTION 1		OPTION 2		OPTION 3		OPTION 4		OPTION 5	
Select one of five plan deductible options:	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Annual Deductible (Individual) PCY (Family* is 3 times the individual deductible)	$500	$1,000	$1,000	$2,000	$1,500	$3,000	$2,500	$5,000	$5,000	$10,000
Coinsurance** (What you pay)	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Annual Coinsurance Maximum (Per individual) PCY	$3,000	$12,000	$3,500	$14,000	$3,500	$14,000	$4,000	$16,000	$4,000	$16,000
Out-of-Pocket Maximum (Deductible + Coinsurance Max)	$3,500	$13,000	$4,500	$16,000	$5,000	$17,000	$6,500	$21,000	$9,000	$26,000
Office Visit Copay	$30 copay	50%	$35 copay	50%	$40 copay	50%	$40 copay	50%	$40 copay	50%

COVERED SERVICES **LIFETIME MAXIMUM:** $3 Million	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER†
PREVENTIVE CARE		
Preventive Exams (includes routine medical exam, sports physical, men's and women's health exam and well baby exam)	Office visit copay	Deductible applies first, then you pay 50%
Preventive Screenings (includes Pap smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)	Covered in full	
Immunizations		
HEALTH EDUCATION		
Health Education & Wellness $200 PCY‡	Covered in full	
Nicotine Dependency Treatment $200 PCY		
PROFESSIONAL CARE		
Office Visit and Urgent Care	No deductible; office visit copay	Deductible applies first, then you pay 50%
ALTERNATIVE CARE		
Spinal & Other Manipulations (includes chiropractic)	No deductible; office visit copay	Deductible applies first, then you pay 50%
Acupuncture & Naturopathic Services 12 shared visits PCY		
DIAGNOSTIC SERVICES		
Diagnostic, X-ray and Imaging	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Laboratory Services	No deductible; you pay 20%	
Mammography	Covered in full	
PHARMACY		
Prescription Drug Benefit (up to 30-day supply)	$15 copay (generic drugs), $40 copay (preferred brand-name drugs), 50% (non-preferred brand-name drugs)	
Mail Service (up to 90-day supply)	$37.50 copay (generic drugs), $100 copay (preferred brand-name drugs), 45% (non-preferred brand-name drugs)	
EMERGENCY CARE		
Emergency Room Care (No copay if admitted)	$150 copay per visit; deductible applies and then you pay 20%	
Ambulance Transportation (air and ground)	Deductible applies first, then you pay 20%	
FACILITY CARE		
Outpatient Care & Inpatient Care	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Skilled Nursing Facility 60 days PCY		
OTHER SERVICES		
Rehabilitation (including Physical, Occupational, Speech, Massage Therapy; Chronic Pain; Cardiac & Pulmonary Rehabilitation) Outpatient: 20 visits PCY; Inpatient: 20 days PCY	Outpatient: No deductible; office visit copay Inpatient: Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Behavioral Health Care/Mental Health Outpatient: 10 visits PCY; Inpatient: 7 days PCY	Deductible applies first, then you pay 50%	
Home Health Care	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Hospice Care Inpatient: 10 days; Respite: 240 hours; home visits unlimited		
Transplants $250,000 lifetime benefit	Deductible applies first, then you pay 20%	Not covered

* Family = Individual plus one or more family members.

** All coinsurance amounts are the member's percentage of allowable charges after deductible.

† Balance billing may apply when an out-of-network provider is used.

‡ Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

NOTE: All coinsurance amounts are based on allowable charges.

PCY = Per Calendar Year

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This is only a summary of the major benefits provided by our Passport plans. It is not a contract.

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