

2017 Benefit Plan Choices

In-network benefits are illustrated

	HDHP-HSA	PPO 90	PPO 80A	PPO 80 B
Deductible – Individual	\$2,600	\$600	\$800	\$2,600
Individual + Children	\$5,200	\$1,050	\$1,400	\$5,200
Individual + Spouse or Family	\$5,200	\$1,200	\$1,400	\$5,200
Out-of-Pocket Maximum (includes deductible)				
Individual	\$6,450	\$5,950	\$5,950	\$6,450
Individual + Children	\$12,900	\$11,350	\$11,500	\$12,900
Individual + Spouse or Family	\$12,900	\$11,500	\$11,500	\$12,900
HSA/HRA Funding	N/A	N/A	N/A	N/A
	N/A	N/A	N/A	N/A
Your Coinsurance	20%	10%	20%	20%
Typical medical services:	You pay:	You pay:	You pay:	You pay:
Primary Care Office Visit	20% after deductible	\$30	\$35	\$40
Specialist Office Visit	20% after deductible	\$50	\$60	\$60
Preventive Care	\$0	\$0	\$0	\$0
Hospital Admission	20% after deductible	\$200 then 10% after deductible	\$200 then 20% after deductible	\$200 then 20% after deductible
Laboratory & Radiology	20% after deductible	10% after deductible	20% after deductible	20% after deductible
Outpatient Facility	20% after deductible	\$100 then 10% after deductible	\$100 then 20% after deductible	\$100 then 20% after deductible
Emergency Room	20% after deductible	\$150 then 10%	\$150 then 20%	\$150 then 20%
		(Deductible does not apply)	(Deductible does not apply)	(Deductible does not apply)
Urgent Care Facility	20% after deductible	\$75 then 10%	\$75 then 20%	\$75 then 20%
		(Deductible does not apply)	(Deductible does not apply)	(Deductible does not apply)