CREATIVE BENEFIT CONSULTANTS

	Plan 5 TIER 1 (AIMM Preferred Programs)	TIER 2 (Standard Benefits)	TIER 3 (Non-Preferred Providers)
DEDUCTIBLE	$0 Single / $0 Family *(embedded deductible)*	$3,500 Single / $7,000 Family *(embedded deductible)*	$7,000 Single / $14,000 Family *(embedded deductible)*
BPA BestLife Wellness Program	Deductible Credits Available Based on Member Participation	Deductible Credits Available Based on Member Participation	Deductible Credits Available Based on Member Participation
CO-INSURANCE	0%	100%	50%
CO-INSURANCE MAXIMUM	$0 Single / $0 Family	$0 Single / $0 Family	$2,500 Single / $5,000 Family
OUT-OF-POCKET LIMIT (all inclusive)	$2,700 Single / $5,400 Family	$5,000 Single / $10,000 Family	$9,500 Single / $19,000 Family
PREVENTIVE SERVICES	100%	100%	100%
PHYSICIAN SERVICES	**Office visit benefit includes all services provided during visit except lab**	**Office visit benefit includes all services provided during visit except lab**	**Office visit benefit includes all services provided during visit except lab**
- Primary Care Office Visit	$5 Copay	$30 Copay	Deductible / Co-insurance
- Specialist Office Visit	$30 Copay	$50 Copay	Deductible / Co-insurance
TELEPHONIC PHYSICIAN CONSULTATIONS	$0 Copay	$0 Copay	$0 Copay
OUTPATIENT LAB	100% if preferred vendor	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT RADIOLOGY AND IMAGING	**Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging**	**Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging**	**Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging**
- Physician Office / Freestanding Imaging Ctr.	100% if preferred vendor	Deductible / Co-insurance	Deductible / Co-insurance
- Hospital Outpatient	100% if preferred vendor	$250 Copay, then Deductible / Co-insurance	$500 Copay, then Deductible / Co-insurance
DIABETIC SUPPLIES	100% if preferred vendor	50% through Rx Benefit	50% through Rx Benefit
OUTPATIENT REHAB & THERAPY	100% if preferred vendor	Deductible / Co-insurance	Deductible / Co-insurance
EMERGENCY SERVICES	**ER Copay waived if admitted**	**ER Copay waived if admitted**	**ER Copay waived if admitted**
- Hospital ER (Facility Charge Only)	$500 Copay, then Deductible / Co-insurance	$500 Copay, then Deductible / Co-insurance	$500 Copay, then Deductible / Co-insurance
- Urgent Care / ER Professional Services	$50 Copay	$50 Copay	$50 Copay
OUTPATIENT SURGICAL PROCEDURES	**Pre-certification required prior to scheduling,**	**Pre-certification required prior to scheduling,**	**Pre-certification required prior to scheduling,**
- Physician Office / Freestanding Surgery Ctr.	100% if preferred vendor	Deductible / Co-insurance	Deductible / Co-insurance
- Hospital Outpatient	100% if preferred vendor	$500 Copay per visit, then Deductible / Co-insurance	$1,000 Copay per visit, then Deductible / Co-insurance
INPATIENT HOSPITALIZATION	**All non-emergency confinements must be pre-certified. Report emergency confinements within 48 hrs of when confinement begins**	**All non-emergency confinements must be pre-certified. Report emergency confinements within 48 hrs of when confinement begins**	**All non-emergency confinements must be pre-certified. Report emergency confinements within 48 hrs of when confinement begins**
- Medical Facility Services	100% if preferred vendor	$500 Copay per confinement, then Ded / Coin	$1000 Copay per confinement, then Ded / Coin
INPATIENT SURGICAL PROCEDURES	100% if preferred vendor	$500 Copay per confinement, then Ded / Coin	$1000 Copay per confinement, then Ded / Coin
ME HEALTH, SKILLED NURSING & HOSPICE CARE	100% if preferred vendor	Deductible / Co-insurance	Deductible / Co-insurance
MENTAL HEALTH & SUBSTANCE ABUSE	100% if preferred vendor	Deductible / Co-insurance	Deductible / Co-insurance
DURABLE MEDICAL EQUIPMENT	100% if preferred vendor	Deductible / Co-insurance	Deductible / Co-insurance
PRESCRIPTION DRUG BENEFITS	Refer to Preferred Formulary and SPD for additional details	Refer to Preferred Formulary and SPD for additional details	
- Generic	$5 Copay (Mail Order $12.50/90 day)	$5 Copay (Mail Order $12.50/90 day)	Not Covered
- Brand	$50 Copay (Mail Order $125/90 day	$50 Copay (Mail Order $125/90 day	Not Covered
Non-Preferred Brand	$80 Copay (Mail Order $200/90)	$80 Copay (Mail Order $200/90)	Not Covered
Specialty Drugs	50% (must utilize Noble Health Programs)	50% (must utilize Noble Health Programs)	Not Covered
- International Mail Order - Brand	$0 Copay if preferred vendor (voluntary participation)	$0 Copay if preferred vendor (voluntary participation)	Not Covered

Please refer to your Summary Plan Document (SPD) for the actual benefit, limitations and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern.