

PPO plans

Plan specifics

M5 PPO

Critical illness (Primary insured only)	\$5,000																				
Calendar-year maximum	\$2,000,000																				
Physician office visit copay Out-of-network physician office visits are subject to the out-of-network deductible and coinsurance.	<ul style="list-style-type: none"> ▶ \$35 copay per in-network physician office visit; after copay, plan pays 100% of the balance of the office visit charge; other covered services performed during the office visit are subject to deductible and coinsurance OR ▶ No copay; covered charges are subject to deductible and coinsurance 																				
Calendar-year deductible In-network and out-of-network deductibles accumulate separately. When the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.	<ul style="list-style-type: none"> ▶ \$1,000 ▶ \$1,500 ▶ \$2,500 ▶ \$3,500 ▶ \$5,000 ▶ \$10,000 ▶ \$20,000 <p>Family deductible: 2 times the individual deductible amount Out-of-network deductible: 2 times the in-network deductible</p>																				
Coinsurance and out-of-pocket maximum Out-of-pocket limits shown are in excess of the deductible. In-network and out-of-network out-of-pocket amounts accumulate separately. When the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.	<table border="0" style="width: 100%;"> <thead> <tr> <th colspan="2" style="text-align: left;"><u>In-network</u></th> <th colspan="2" style="text-align: left;"><u>Out-of-network</u></th> </tr> <tr> <th style="text-align: left;"><u>Coinsurance</u></th> <th style="text-align: left;"><u>Out-of-pocket</u></th> <th style="text-align: left;"><u>Coinsurance</u></th> <th style="text-align: left;"><u>Out-of-pocket</u></th> </tr> </thead> <tbody> <tr> <td>▶ 100%</td> <td>\$0</td> <td>70%</td> <td>\$3,000</td> </tr> <tr> <td>▶ 80%</td> <td>\$4,000</td> <td>60%</td> <td>\$8,000</td> </tr> <tr> <td>▶ 50%</td> <td>\$6,000</td> <td>50%</td> <td>\$12,000</td> </tr> </tbody> </table> <p>Family out-of-pocket: 2 times the individual out-of-pocket amount</p>	<u>In-network</u>		<u>Out-of-network</u>		<u>Coinsurance</u>	<u>Out-of-pocket</u>	<u>Coinsurance</u>	<u>Out-of-pocket</u>	▶ 100%	\$0	70%	\$3,000	▶ 80%	\$4,000	60%	\$8,000	▶ 50%	\$6,000	50%	\$12,000
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Outpatient prescription drugs <i>If you find a drug for less than the copay amount, you pay that cost, not the full copay!</i>	<ul style="list-style-type: none"> ▶ Generic: No copay Brand name/formulary: \$250 deductible¹, then \$50 copay Brand name/non-formulary: \$500 deductible¹, then \$75 copay Specialty medication: 50% coinsurance OR ▶ Generic: \$15 copay Brand name/formulary: \$50 copay Brand name/non-formulary: \$75 copay Specialty medication: 50% coinsurance OR ▶ Generic: \$20 copay All other covered outpatient prescription drugs: same as any other illness; subject to deductible and coinsurance OR ▶ Discount only; prescription drugs will not be covered expenses and will not apply toward deductible or coinsurance. (The discount is available at participating pharmacies and is not an insurance benefit.) 																				
Routine mammography and Pap smear	100%—in- and out-of-network covered charges are not subject to copay, deductible or coinsurance																				
Wellness benefits Covered services include a routine physical exam, well-child exams, PSA test, digital screening and colorectal cancer examination.	<p>In-network: 100%—covered charges are not subject to copay, deductible or coinsurance</p> <p>Out-of-network: Subject to the out-of-network deductible and coinsurance</p>																				
Preventive services Covered preventive services are those rated with an “A” or “B” by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit: www.uspreventiveservicestaskforce.org .	<p>In-network: 100%—covered charges are not subject to copay, deductible or coinsurance</p> <p>Out-of-network: No coverage</p>																				
ER copay	\$100; then subject to in-network deductible and coinsurance (Waived if admitted inpatient immediately following emergency room visit.)																				
Outpatient surgical services copay	No copay; subject to deductible and coinsurance																				
Inpatient hospital confinement copay	No copay; subject to deductible and coinsurance																				

¹ Deductibles are per covered person per calendar year up to a maximum of three per family.

Traditional plans

Plan specifics	M5 Traditional								
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Calendar-year maximum	\$2,000,000								
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Calendar-year deductible	<ul style="list-style-type: none"> <li style="width: 50%;">▶ \$1,000 <li style="width: 50%;">▶ \$5,000 <li style="width: 50%;">▶ \$1,500 <li style="width: 50%;">▶ \$10,000 <li style="width: 50%;">▶ \$2,500 <li style="width: 50%;">▶ \$20,000 <li style="width: 50%;">▶ \$3,500 Family deductible: 2 times the individual deductible amount								
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¹ Deductibles are per covered person per calendar year up to a maximum of three per family.

Benefit limitations (Limitations apply to PPO and Traditional plans)	M5 and HSA5	N2
Physical, speech and occupational therapies After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of 30 treatments for one type of therapy and up to 60 treatments for any combination of therapies per calendar year per covered person	Maximum of 20 treatments for one type of therapy and up to 40 treatments for any combination of therapies per calendar year per covered person
Home health care After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of 35 visits per calendar year per covered person	Maximum of 21 visits per calendar year per covered person
Organ transplant: Center of Excellence provider If a Center of Excellence is utilized, a travel expense allowance is included for up to \$5,000 for one companion, or two companions if the insured is a minor.	Subject to the policy's calendar-year maximum of \$2,000,000	Subject to the policy's calendar-year maximum of \$1,000,000
Organ transplant: provider not listed as a Center of Excellence	Maximum benefit of \$250,000 per transplant	
Skilled nursing facility care After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of \$100 per day, per covered person	
Outpatient mental or nervous disorders and chemical dependency disorders	Maximum of \$25 per visit, subject to deductible and coinsurance (Benefits are not provided for inpatient chemical dependency treatment.)	
Inpatient mental or nervous disorders	Maximum of \$250 per day, subject to deductible and coinsurance	
Non-surgical back treatment (Including but not limited to chiropractic care)	Maximum of 10 visits per calendar year per covered person, subject to deductible and coinsurance	
Hospice care	The plan will pay covered expenses for hospice care for up to six months, not subject to any copays, deductible or coinsurance ¹	

¹ Hospice charges on the HSA5 plans are subject to deductible and coinsurance

Optional benefits

Supplemental accident

Your family's active lifestyle can lead to bumps and bruises along the way. Our supplemental accident benefit pays 100 percent up to the selected per-accident maximum of \$500, \$1,000 or \$2,500 and applies for covered charges incurred for treatment of an accidental bodily injury. This benefit also covers follow-up care received within three months from the date of the accident and is available for an unlimited number of accidents while coverage under the rider is inforce. Covered charges incurred after the maximum benefit is paid, or more than three months after the accident, are subject to deductible and coinsurance.

Life insurance

mPowerMed offers a term life insurance benefit for you as the primary insured. If you elect life insurance coverage, you may select a benefit from \$10,000 to \$100,000, in increments of \$10,000. The life insurance benefit is payable as long as the mPowerMed health plan is inforce on the date of the primary insured's death.*

* Term life insurance benefits are subject to a reduction schedule based on age. The selected life benefit amount will be reduced to a percentage of that amount as follows: age 65-69: 65 percent, age 70-74: 40 percent, age 75-79: 25 percent, age 80-84: 15 percent, age 85+: 10 percent. Death by suicide, while sane or insane, is not covered if the death occurs within 12 months of the effective date of coverage under this rider.