The Basic PPO Plan

- Covers 100% of preventive care services provided in-network (according to age and gender)
- Offers the predictability of copayments for many services
- Allows deductibles, coinsurance and copayments to accumulate toward the out-of-pocket maximum
- Will have the best value when you choose Tier 1 in-network healthcare providers
- Allows you to visit any provider

Basic PPO Plan	TIER 1	TIER 2	TIER 3
	Southwest and UHHS Facilities *(Excluding Elyria, Parma and MetroHealth)*	**SuperMed Plus Network, including Elyria** *(Excluding Parma, CCHS and MetroHealth)*	**Non-Network Providers** *(Including CCHS, CCHS Affiliates, Parma and MetroHealth)*
	YOU PAY	**YOU PAY**	**YOU PAY**
Annual Deductible *(Individual/Family)*	$450/$900	$900/$1,800	$3,000/$6,000
Coinsurance	25%	45%	45% R&C[1]
Annual Out-of-Pocket Maximum *(Individual/Family)*	$4,000/$8,000	$6,850/$13,700	$22,500/$45,000
Lifetime Maximum	Unlimited		
Preventive Care	$0	$0	Deductible then 50% Coinsurance
Primary Care Office Visit	$20 Copay	$20 Copay	Deductible then 45% Coinsurance
Specialist Office Visit	$40 Copay	$40 Copay	Deductible then 45% Coinsurance
Teladoc Virtual Visit	$20 Copay	N/A	N/A
Diagnostic[2]	$0	45%	Deductible then 45% Coinsurance
Inpatient Hospital Services	$250 Copay + Deductible then 25% Coinsurance	$250 Copay then 45%	Deductible then 45% Coinsurance
Surgical Services	Deductible then 25% Coinsurance	Deductible then 25% Coinsurance	Deductible then 45% Coinsurance
Outpatient Hospital Services	$0	Deductible then 45% Coinsurance	Deductible then 45% Coinsurance
Outpatient Surgical Services	Deductible then 25% Coinsurance	Deductible then 45% Coinsurance	Deductible then 45% Coinsurance
Urgent Care	$40 Copay	$60 Copay	Deductible then 45% Coinsurance
Emergency Room Care *(Waived if admitted)*	$250 Copay[3]		
Bariatric Surgery	$250 Copay + Deductible then 25% Coinsurance	$250 Copay then 45%	Deductible then 45% Coinsurance
Transplant Services – Performed at Centers for Excellence[4] *(Prior authorization is required)*	$0	$0	Deductible then 50% Coinsurance
Hospice Care	Deductible then 25% Coinsurance	Deductible then 45% Coinsurance	Deductible then 45% Coinsurance
Durable Medical Equipment	Deductible then 25%	Deductible then 45% Coinsurance	Deductible then 45% Coinsurance
Temporomandibular Joint – TMJ	Deductible then 25% Coinsurance	Deductible then 45% Coinsurance	No Coverage
Mental Health and Substance Abuse **Inpatient** **Outpatient**	Deductible then 25% Coinsurance $20 Copay	Deductible then 45% Coinsurance $20 Copay	Deductible then 45% Coinsurance Deductible then 45% Coinsurance

[1] You will be responsible for paying any amount in excess of R&C (Reasonable and Customary allowed amount) in addition to the Deductible and Coinsurance.
[2] Prior authorization is required for all CT, PET and MRI scans; not covered under Tier 3.
[3] Waived if admitted.
[4] Performed at Centers for Excellence. Prior authorization is required.