Level Funded Employer VEBA PPO Plans

Synchrony Health Initiatives

Effective Date: 1/1/20

	$1,000 Plan Traditional PPO	$2,000 Plan Traditional PPO
Deductible & Maximums	**In-Network**	**In-Network**
Deductible (Individual/Family)	$1,000/$2,000	$2,000/$4,000
Out-of-Pocket Maximum - Individual/Family (includes deductible)	$2,500/$5,000	$5,000/$10,000
Coinsurance (Insurance/Patient)	80%/20%	80%/20%
Annual Maximum/Lifetime Maximum	Unlimited	Unlimited
Physician Services		
Preventative Care/Routine Exams	Covered at 100%	Covered at 100%
Primary Care - Office Visit	$25 Copay	$40 Copay
Specialist - Office Visit	$45 Copay	$60 Copay
Urgent Care Visit (Designated Urgent Care Clinic)	$60 Copay	$60 Copay
Diagnostic Services		
Routine Preventative Care - Exam/Screening	Covered at 100%	Covered at 100%
Diagnostic Laboratory	80% After Deductible	80% After Deductible
Diagnostic X-Ray	80% After Deductible	80% After Deductible
Diagnostic X-Ray for Complex Imaging Services	80% After Deductible	80% After Deductible
Emergency Medical Care		
Emergency Room Visit	$200 Copay	$300 Copay
Non-Emergency ER Visit	80% After Deductible	80% After Deductible
Ambulance	80% After Deductible	80% After Deductible
Hospital Care		
Inpatient Hospitalization	80% After Deductible	80% After Deductible
Outpatient Surgery	80% After Deductible	80% After Deductible
Mental Health and Substance Abuse Services		
Inpatient Detoxification	80% After Deductible	80% After Deductible
Inpatient Substance Abuse Rehab & Mental Health treatment	80% After Deductible	80% After Deductible
Outpatient Substance Abuse Rehab & Mental Health treatment	$45 Copay	$60 Copay
Other Benefits		
Rx (Generic/Formulary Brand-name/Non-Formulary Brand-name)	$15/$50/$90	$15/$50/$90
Specialty Drugs	25% up to $300	35% up to $300
Mail Order (90-day Supply)	$30/$100/$225	$30/$100/$225
Routine Eye Exam (Children)	Covered at 100%	Covered at 100%
Skilled Nursing Facility	80% After Deductible	80% After Deductible
Non-Network Benefits	**Out of Network**	**Out Of Network**
Calendar Year Deductible (Individual/Family)	$3,000/$6,000	$6,000/$12,000
Calendar Yr. Out of Pocket Maximum (Individual/Family)	$6,000/$12,000	$12,000/$24,000
Coinsurance (Insurance/Patient)	60%/40%	60%/40%
Lifetime Maximum	Combined w/In-Network	Combined w/In-Network
Physician Office Visits	60% After Deductible	60% After Deductible
Inpatient Hospitalization	60% After Deductible	60% After Deductible
Outpatient Surgery	60% After Deductible	60% After Deductible
Diagnostic Services	60% After Deductible	60% After Deductible
Mental Health and Substance Abuse Services	60% After Deductible	60% After Deductible
Emergency Room Visit / Non-Emergcency ER Visit	$200 Copay / 60% After Deductible	$300 Copay / 60% After Deductible

1) All pharmacy is subject to annual prescription deductibles and out of pocket limits. Pharmacy copays will apply after prescription deductible is met and these copays will be applied to the out of pocket limits.

2) All pharmacy benefits, including all medications, are subject to formulary, clinical and administrative programs effective at the time of claim adjudication, prior to dispensing and are subject to change.

3) All Specialty pharmacy requires Clinical Pharmacy review and approval prior to dispensing.