

	BILH Network High Deductible HSA		BILH Network Premier HMO		Flex HMO			Access PPO	
	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2	Tier 3	In-Network	Out-of-Network
Annual Deductible	\$2,000 member/ \$4,000 family (includes prescription drug costs)	\$4,000 member/ \$8,000 family (includes prescription drug costs)	\$800 member/ \$1,600 family	\$2,500 member/ \$5,000 family	\$800 member/ \$1,600 family	\$2,500 member/ \$5,000 family	\$6,000 member/ \$12,000 family	\$500 member/ \$1,000 family	\$2,000 member/ \$4,000 family
BILH Maximum Annual HSA Contribution <i>(on a per-pay period basis)</i>	\$1,000 member/\$2,000 family		Not Applicable		Not Applicable			Not Applicable	
Out-of-Pocket Maximum* (Includes medical copays, coinsurance and deductibles)	\$5,000 member/ \$10,000 family (includes prescription drug costs)	\$7,500 member/ \$15,000 family (includes prescription drug costs)	\$2,750 member/\$5,500 family		\$7,500 member/\$15,000 family			\$6,000 member/\$12,000 family	
Preventive Care Visits	\$0 (covered in full)		\$0 (covered in full)		\$0 (covered in full)			\$0 (covered in full)	30% coinsurance after deductible
PCP Office Visits	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	\$0 (covered in full)	\$50 copay (covered in full for children ages 18 and under)	\$0 (covered in full)	\$50 copay (covered in full for children ages 18 and under)	\$80 copay (\$50 copay for children ages 18 and under)	\$40 copay	30% coinsurance after deductible
Specialist Office Visits	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	\$40 copay	\$100 copay (\$40 copay for children ages 18 and under)	\$40 copay	\$100 copay (\$40 copay for children ages 18 and under)	\$160 copay (\$100 copay for children ages 18 and under)	\$40 copay	30% coinsurance after deductible
Outpatient Mental Health/ Substance Use Disorder Treatment	20% coinsurance after deductible		\$0 (covered in full)		\$0 (covered in full)			\$0 (covered in full)	30% coinsurance after deductible
Inpatient Mental Health/ Substance Use Disorder Treatment	20% coinsurance after deductible		10% coinsurance after deductible		10% coinsurance after deductible			10% coinsurance after deductible	30% coinsurance after deductible
Urgent Care	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	\$40 copay	\$100 copay (\$40 copay for children ages 18 and under)	\$40 copay	\$100 copay (\$40 copay for children ages 18 and under)	\$160 copay (\$100 copay for children ages 18 and under)	\$40 copay	30% coinsurance after deductible
Emergency Room (ER) Care (Waived if admitted)	20% coinsurance after deductible	20% coinsurance after deductible	\$200 copay		\$200 copay			\$150 copay	
Emergency Admission	20% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible		10% coinsurance after deductible			10% coinsurance after deductible	
Inpatient Hospital	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	50% coinsurance after deductible (30% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible
Day Surgery (Including diagnostic scoping procedures)	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	50% coinsurance after deductible (30% coinsurance after deductible for children ages 18 and under)	10% coinsurance after deductible	30% coinsurance after deductible
Hospital Based Lab/X-Ray/ Diagnostic and High End Radiology (MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	\$40 copay	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	\$40 copay	30% coinsurance after deductible (10% coinsurance after deductible for children ages 18 and under)	50% coinsurance after deductible (30% coinsurance after deductible for children ages 18 and under)	\$40 copay	30% coinsurance after deductible
Non-Hospital Based Lab/X-Ray/ Diagnostic and High End Radiology (MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible (20% coinsurance after deductible for children ages 18 and under)	\$40 copay	\$100 copay (\$40 copay for children ages 18 and under)	\$40 copay	\$100 copay (\$40 copay for children ages 18 and under)	\$160 copay (\$100 copay for children ages 18 and under)	\$40 copay	30% coinsurance after deductible

Prescription Drug Coverage		BILH Network High Deductible HSA	BILH Network Premier HMO		Flex HMO			Access PPO	
Deductible**		Combined with Medical Deductible: \$2,000 member/\$4,000 family for BILH Pharmacy & Home Delivery; \$4,000 member/\$8,000 family for Retail Pharmacy	N/A		N/A			N/A	
Preventive Medications		\$0 (covered in full)	\$0 (covered in full)		\$0 (covered in full)			\$0 (covered in full)	
BILH Pharmacy and Home Delivery – 30 Day Supply	Generic	20% coinsurance after deductible	\$5		\$5			\$10	
	Preferred		\$25		\$25			\$30	
	Non-preferred		\$40		\$40			\$60	
	Specialty		\$40		\$40			\$100	
BILH Pharmacy and Home Delivery – 90 Day Supply	Generic	20% coinsurance after deductible	\$12.50		\$12.50			\$25	
	Preferred		\$62.50		\$62.50			\$75	
	Non-preferred		\$100		\$100			\$150	
	Specialty		\$40		\$100			\$250	
Retail Network Pharmacy – 30 Day Supply Only	Generic	40% coinsurance after deductible for generic, preferred, and non-preferred Specialty medications not covered	\$10		\$10			\$10	
	Preferred		\$30		\$30			\$30	
	Non-preferred		\$60		\$60			\$60	
	Specialty		Not covered		Not covered			Not covered	
Out-of-Pocket Maximum		Combined with Medical Out-of-Pocket Maximum: \$5,000 member/\$10,000 family for BILH Pharmacy & Home Delivery; \$7,500 member/\$15,000 family for Retail Pharmacy	Separate Prescription Drug Out-of-Pocket Maximum: \$3,000 member/\$6,000 family		Separate Prescription Drug Out-of-Pocket Maximum: \$3,000 member/\$6,000 family			Separate Prescription Drug Out-of-Pocket Maximum: \$3,000 member/\$6,000 family	

* In the BILH Network High Deductible HSA plan, prescription drug costs are combined with the Out-of-Pocket Maximums. In the BILH Network Premier, Flex HMO, and Access PPO plans, prescription drugs have separate Out-of-Pocket Maximums. Therefore, in those plans, prescription drug costs do not count toward meeting the medical Out-of-Pocket Maximums.

** Deductible does not apply for generic drugs on the [HDHP Preventive Drug list](#).

Note: Family applies when one or more dependents are enrolled in the plan.