This will replace the current Traditional Plan and is for retirees only.

	PPO A	
	In-network	**Out-of-network**
SERVICE AREA	Potentially nationwide	Unrestricted
HOSPITAL INPATIENT	100% .	80% after $200 per hospital stay deductible.
SKILLED NURSING FACILITY	100% up to 120 days per calendar year	80% for up to 60 days per calendar year
HOSPITAL PRE-ADMISSION TESTING	100%	80% after deductible
PHYSICIAN (SURGERY)	100%	80% after deductible
PHYSICIAN (OFFICE VISITS)	100% after $10 copayment per visit	80% after deductible; No coverage for wellness care
CHIROPRACTIC	100% after $10 per visit copayment; 30 visits per calendar year	80% after deductible for up to 30 visits per calendar year combined in-network and out-of-network
HOSPITAL EMERGENCY ROOM	100% after $25 copayment (waived if admitted) if reported within 48 hours;	100% after $25 copayment (waived if admitted) if reported within 48 hours; if not reported within 48 hours, subject to deductible and coinsurance
IMMUNIZATIONS	100% after $10 copayment per visit (except for travel and/or job related)	80% for children under 12 months, after deductible
MATERNITY	$10 copayment for first prenatal office visit then 100% covered	80% after deductible
PHYSICAL EXAMS	100% after $10 copayment per visit	Not covered
WELL BABY	100% after $10 copayment per visit	Not covered
RADIATION/ CHEMOTHERAPY OUTPATIENT	100%	80% after deductible
HOSPICE	100%	80% after deductible
PHYSICAL/SPEECH THERAPY	100% after $10 copayment per visit	80% after deductible
LAB TESTS	100%	80% after deductible
ROUTINE VISION EXAM	100% after $10 copayment; one exam per calendar year, no referral needed	None
ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness
DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness
ALCOHOL ABUSE (OUTPATIENT)	100%, no visit limit	80% after deductible
DRUG ABUSE (OUTPATIENT)	100%, no visit limit	80% after deductible
MENTAL HEALTH[1] (INPATIENT)	100% up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual lifetime maximums
MENTAL HEALTH[1] (OUTPATIENT)	90% up to annual and/or lifetime maximums	80% after deductible up to annual and/or lifetime maximums
HOME HEALTH CARE	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered; subject to out-of-network insurance and deductible
DISEASE MANAGEMENT	Yes	N/A
PRIVATE DUTY NURSING (Must be Medically Necessary)	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities

INFERTILITY SERVICES	Diagnosis covered; treatment covered with limitations	Treatment covered with limitations; subject to out-of-network insurance and deductible
DEDUCTIBLES (INDIVIDUAL)	None	$100 per calendar year; $200 per hospital admission
DEDUCTIBLES (FAMILY MAXIMUM)	None	$250 per calendar year; $200 per hospital admission
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	Unlimited; $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year, up to $50,000[3]	$1,000,000 lifetime (major medical expense only); $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year up to $50,000[3]
[1]Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.		