

Educators Health Alliance
2009-10 Benefit Summary for PPO Health Coverage

Benefit Item	Preferred	Non-Preferred
Each PPO Subgroup May Choose 1 of 4 Deductible Options:		
Employee Only Deductible		
Deductible Option 1	\$350	\$700
Deductible Option 2	\$600	\$1,200
Deductible Option 3	\$800	\$1,600
Deductible Option 4	\$1,100	\$2,200
Family Deductible Maximum	Twice Deductible	Twice Deductible
Coinsurance - Options 1 & 2		
	20%	40%
Individual Coinsurance Maximum	\$2,000	\$4,000
Family Coinsurance Maximum	\$4,000	\$8,000
<i>Excludes Deductible</i>		
Coinsurance - Options 3 & 4		
	20%	40%
Individual Coinsurance Maximum	\$2,250	\$4,500
Family Coinsurance Maximum	\$4,500	\$9,000
<i>Excludes Deductible</i>		
Contract Maximum	\$5,000,000	
Office Visit Copay	\$35	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	
Outpatient Hospital	Deductible & Coinsurance	
Emergency Services	Deductible & Coinsurance	
Prescription Drugs		
Generic Copay	25% Coinsurance (\$5 min. / \$25 max.)	
Formulary Brand Copay	25% Coinsurance (\$30 min. / \$60 max.)	
Non-Formulary Brand Copay	50% Coinsurance (\$60 min. / \$90 max.)	
In-Network Specialty Copay (Per 30-Day Supply)	25% Coinsurance (\$50 min. / \$100 max.)	
Out-of-Network Specialty Copay (Per 30-Day Supply)	50% Coinsurance (\$150 min. / \$300 max.)	
Formulary Diabetic Supplies	20% Coinsurance	
Non-Formulary Diabetic Supplies	30% Coinsurance	
Ostomy Supplies	20% Coinsurance	
Maximum Copay - Single	\$2,500	
Maximum Copay - Family	\$5,000	
Mail Order Maximum	180-Day Supply	
Mail Order Copay	1 Copay Per 30-Day Supply; 5 Copay Maximum	
Preauthorization Programs Included	Cox-2, Proton Pump Inhibitors, and Leukotriene Modifiers	
Routine Care		
Adults & Children Age 5 and Older	\$500 Calendar Year Benefit Maximum; Subject To Deductible & Coinsurance	
Routine Mammograms, Pap Smears, PSA Tests and Immunizations	In-Network: No Deductible Or Coinsurance Out-of-Network: Deductible & Coinsurance	
Well Baby Care	Deductible Waived; Coinsurance Only	
Mental Health and Substance Abuse		
Inpatient Coinsurance	20%	50%
Outpatient Coinsurance	\$30 / 25%	\$50 / 50%