

**Educators Health Alliance**  
**2024-25 Benefit Summary for PPO Health Coverage - Alternate Networks Option 2**

Benefit Plan	Preferred	Non-Preferred
<b>Each Subscriber may choose 1 of 3 Network Options:</b>		
<b>Individual Deductible</b>		
Blueprint Health Deductible (Paired with \$2,500 HSA-Eligible Plan)	\$400	\$800
Premier Select BlueChoice Deductible (Paired with \$2,500 HSA-Eligible Plan)	\$400	\$800
NEtwork Blue Deductible (Paired with \$3,800 HSA-Eligible Plan)	\$1,900	\$3,800
<b>Family Deductible Maximum</b>	2x Individual	2x Individual
<b>Blueprint Health Coinsurance</b>		
	20%	40%
<b>Premier Select BlueChoice Coinsurance</b>		
	20%	40%
<b>NEtwork Blue Coinsurance</b>		
	20%	40%
<b>Individual Out-of-Pocket Maximum by Deductible Option</b>		
Blueprint Health Out-of-Pocket Maximum	\$5,000	\$10,000
Premier Select BlueChoice Out-of-Pocket Maximum	\$5,000	\$10,000
NEtwork Blue Out-of-Pocket Maximum	\$5,500	\$11,000
<b>Family Out-of-Pocket Maximum</b>	2x Individual	2x Individual
<i>Combined Maximum includes Deductible, Coinsurance, and Copays for all services including Prescription Drugs</i>		
<b>Lifetime Maximum</b>		
	Unlimited	
<b>Office Visit Copay</b>		
Primary Copay	\$35	Ded & Coins
Specialist Copay	\$55	Ded & Coins
<b>Inpatient Hospital</b>		
	Ded & Coins	
<b>Outpatient Hospital</b>		
	Ded & Coins	
<b>Emergency Services</b>		
Urgent Care	\$55 Copay, Ded & Coins	
Emergency Room	\$85 Copay, Ded & Coins	
<b>Prescription Drugs</b>		
Generic Copay	25% Coins (\$10 minimum, \$40 maximum)	
Formulary Brand Copay	25% Coins (\$50 minimum, \$100 maximum)	
Non-Formulary Brand Copay	50% Coins (\$75 minimum, \$150 maximum)	
In Network Specialty Copay (30 Day Supply)	25% Coins (\$125 minimum, \$250 maximum)	
Out of Network Specialty Copay (30 Day Supply)	N/C	
Formulary Diabetic Supplies	20%	
Non-Formulary Diabetic Supplies	30%	
Mail Order Maximum	180 Days Supply	
Mail Order Copay	1 Copay per 30 Days Supply with 5 Copay Maximum	
Preauthorization Programs Included	Gastroprotective NSAIDs and Proton Pump Inhibitors	
<b>Preventive Services</b>		
	Covered at 100%	Ded & Coins
<b>Mental Health and Substance Abuse</b>		
Inpatient	Ded & Coins	
Outpatient	Ded & Coins	
Office Visit	Covered at 100%	Ded & Coins

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.