BENEFIT	High Deductible Health Plan (HDHP)			PPO Health Plan			Out of Area Plan (Only available to those living ~50 miles or more from SPH Hospital)	
	Tier 1 (SPH/Partner Providers)	Tier 2 (Allegiance Network)	Out-Of -Network	Tier 1 (SPH/Partner Providers)	Tier 2 (Allegiance Network)	Out-Of -Network	Tier 1 (Cigna OAP Network)	Out-Of -Network
Medical Plan								
Annual/Calendar Year Deductible (Ded) *(Individual/Family)*	$1,600/$3,200	$6,000/$12,000	$9,000/$18,000	$1,000/$2,000	$7,500/$15,000	$9,100/$18,200	$3,000/$6,000	$9,100/$18,200
Out of Pocket Max *(Individual/Family)*	$3,200/$6,400	$9,000/$18,000	Unlimited	$3,000/$6,000	$9,000/$18,000	Unlimited	$6,000/$12,000	Unlimited
Coinsurance *(% you pay/%paid by insurance)*	10%/90%	30%/70%	50%/50%	20%/80%	30%/70%	50%/50%	10%/90%	50%/50%
Preventative Care	100% Covered	100% Covered	Not Covered	100% Covered	100% Covered	Not Covered	100% Covered	Not Covered
Office Visit - *Critical services not offered by SPH e.g. OBGYN, Pediatric, Dermatology*	Ded - 10%	Ded-30%	Ded-50%	$25 Copay	Ded-30%	Ded-50%	Ded-10%	Ded-50%
Specialist Visit	Ded - 10%	Ded-30%	Ded-50%	$35 Copay	Ded-30%	Ded-50%	Ded-10%	Ded-50%
Telemedicine *via MDLive*	$25 Copay	Not Applicable	Not Applicable	$25 Copay	Not Applicable	Not Applicable	$25 Copay	Not Applicable
TeleBehavioral Health *via Talkspace, Brightside Health & Brightline*	Ded - 10%	Not Applicable	Not Applicable	$25 Copay	Not Applicable	Not Applicable	$35 Copay	Not Applicable
High Cost Diagnostics	Ded - 10%	Ded-30%	Ded-50%	$150 Copay	Ded-30%	Ded-50%	Ded-10%	Ded-50%
Out Patient Surgery	Ded - 10%	Ded-30%	Ded-50%	Ded-20%	Ded-30%	Ded-50%	Ded-10%	Ded-50%
Lab/X-ray Services	Ded - 10%	Ded-30%	Ded-50%	100% Covered	Ded-30%	Ded-50%	Ded-10%	Ded-50%
Emergency Care	$150 Copay -Ded	$150 Copay -Ded	$150 Copay -Ded	$150 copay-Ded/ 10%	$150 copay-Ded/ 10%	$150 copay-Ded/ 10%	$250 Copay - Ded/10%	$250 Copay - Ded/10%
Urgent Care	Ded - 10%	Ded-30%	Ded-50%	$40 Copay	Ded- 30% Unless over 100 Miles from Helena then $70 Copay	Ded-50%	Ded-10%	Ded-50%
Behavioral Health Visit	Ded - 10%	Ded-30%	Ded-50%	$25 Copay	$35 Copay	Ded-50%	$35 Copay	Ded-50%
Chiropractic Care *(up to 24 visits/year)*	Ded - 10%	Ded-30%	Ded-50%	$30 Copay	$30 Copay	Ded-50%	Ded-10%	Ded-50%
Acupuncture *(up to 24 visits/year)*	Ded - 10%	Ded-30%	Ded-50%	$30 Copay	$30 Copay	Ded-50%	Ded-10%	Ded-50%

Note: Deductibles, copays, and coinsurance accumulate towards out-of-pocket maximums.
Note: Subject to deductible, unless stated otherwise-copays not subject to deductible.

	High Deductible Health Plan (HDHP)			PPO Health Plan			Out of Area Plan (Only available to those living 100 miles or more from SPH Hospital)		
	St. Peter's Pharmacy	Mail Order	Optum Rx	St. Peter's Pharmacy	Mail Order	Optum Rx	Optum Rx	Mail Order	Out-Of-Network
Prescription Drugs									
Generic	Ded - 0%	Ded-30%	Ded-30%	$0 Copay	20% up to $150	20% up to $150	$0 Copay	$0 Copay	Not applicable
Brand	Ded - 10%	Ded-30%	Ded-30%	20% up to $100	20% up to $300	20% up to $300	20% up to $100	20% up to $100	Not applicable
Specialty*	Ded - 10%	Exceptions Only	Exceptions Only	30% up to $300	Exceptions Only	Exceptions Only	30% up to $500	30% up to $500	Not applicable
Retail Supply Limits	90 days	90 days	30 days	30 days for 1 copay 31-60 days for 2 copays 61-90 days for 3 copays	90 days	30 days	90 days	90 days	Not applicable

*Specialty limited to 30-day supply
NOTE: Mail order is 3 times the Retail copay for a 90-day supply, and is not covered out-of-network
NOTE: Extended Supply Network Pharmacy: 90-day supply
NOTE ON GENERIC SUBSTITUTION: Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic is available
NOTE: There is a possibility for limited reimbursement if claims are submitted manually direct to Optum Rx