Suffolk University Benefit Plan Options 2019

	HMO	PPO		Best Buy HMO	High Deductible PPO Plan with HSA	
Benefits	**In Network Benefits Only**	**In Network**	**Out of Network**	**In Network Benefits Only**	**In Network**	**Out of Network**
Annual Deductible	None	None	$750 Per Member $1,500 Family Maximum	$500 per member $1,000 per family	$1,500 per Single $3,000 per family	$3,000 Per Single $6,000 Per Family
Routine Office Visits	$0 copay	$0 copay	Covered 80% after deductible	$0 copay, no deductible	$0 copay, no deductible	Covered 80% no deductible
PCP Office Visits	$25 copay	$25 copay	Covered 80% after deductible	$25 copay, no deductible	Covered in full after deductible	Covered 80% after deductible
Specialist Office Visits	$25 copay	$25 copay	Covered 80% after deductible	$25 copay, no deductible	Covered in full after deductible	Covered 80% after deductible
Chiropractic Visits	$25 copay	$25 copay	Covered 80% after deductible	$25 copay, no deductible	Covered in full after deductible	Covered 80% after deductible
Annual Eye Exam	$25 copay	$25 copay	Covered 80% after deductible	$25 copay, no deductible	$25 copay, no deductible	80% after deductible
Diagnostic Tests	Covered in full	Covered in full	Covered 80% after deductible	Covered in full after deductible	Covered in full after deductible	Covered 80% after deductible
MRI, CT Scan, PET Scan	$75 copay per test	$75 copay per test	Covered 80% after deductible	$75 copay per test	Covered in full after deductible	Covered 80% after deductible
Inpatient Hospital	$250 copay	$250 copay	Covered 80% after deductible	$250 copay after deductible	Covered in full after deductible	Covered 80% after deductible
Outpatient Surgery Copay	$150 copay	$150 copay	Covered 80% after deductible	$150 copay after deductible	Covered in full after deductible	Covered 80% after deductible
Emergency Room	$150 copay	$150 copay		$150 copay	Covered in full after in-network deductible	
Prescription Drugs Retail *(30 day supply)* Mail Order *(90 day supply)*	$5/$20/$30/$50 $10/$40/$60/$150	$5/$20/$30/$50 $10/$40/$60/$150	Not Covered Not Covered	$5/$20/$30/$50 $10/$40/$60/$150	Plan Deductible Applies, then Copays $5/$20/$30/$50 $10/$40/$60/$150	
Out-of-Pocket Maximum	$2,500 Per Member $5,000 Per Family	$2,500 Per Member $5,000 Per Family	$2,500 Per Member $5,000 Per Family	$2,500 Per Member $5,000 Per Family	$3,000 Per Member $6,000 Per Family	$6,000 Per Member $12,000 Per Family

Pharmacy Copayments

Tier 1 (T1): Lowest cost generics / Tier 2 (T2): Primarily higher cost generics / Tier 3 (T3): Mostly brand name drugs without generic equivalents / Tier 4 (T4): Drugs not included in Tier 1, 2 or 3

This is intended to be a summary only; please refer to the Schedule of Benefits for detailed information available at www.hphc.org/suffolkuniversity or by calling (888) 333-4742.