Educators Health Alliance
2027-28 Benefit Summary for PPO Health Coverage

Benefit Plan	Preferred	Non-Preferred
Subgroups with these options $1,650, $1,900, $2,100, $2,250, $2,500, $3,000 , may take this plan as a dual option.		
Individual Deductible	$3,800	$7,600
Family Deductible Maximum	$7,600	$15,200
Coinsurance	30%	40%
Individual Out-of-Pocket Maximum	$10,150	$20,300
Family Out-of-Pocket Maximum	$20,300	$40,600
Combined Maximum includes Deductible, Coinsurance, and Copays for all services including Prescription Drugs		
Lifetime Maximum	Unlimited	
Office Visit Copay		
Primary Copay	$50	Ded & Coins
Specialist Copay	$70	Ded & Coins
Inpatient Hospital	Ded & Coins	
Outpatient Hospital	Ded & Coins	
Emergency Services		
Urgent Care	$70 Copay, Ded & Coins	
Emergency Room	$150 Copay, Ded & Coins	
Prescription Drugs		
Generic Copay	50% Coins ($12 minimum, $45 maximum)	
Formulary Brand Copay	30% Coins ($70 minimum, $140 maximum)	
Non-Formulary Brand Copay	50% Coins ($110 minimum, $220 maximum)	
In Network Specialty Copay (30 Day Supply)	30% Coins ($150 minimum, $300 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	
Preventive Services	Covered at 100%	Ded & Coins
Mental Health and Substance Abuse		
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.