

	Saver/2,700		PPO/1,100		PPO/1,600	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Savings Account Type	Health Savings Account (HSA)		Health Reimbursement Arrangement (HRA)		Health Reimbursement Arrangement (HRA)	
Initial WKU Credit (Single / Family)	\$800 / \$1,300		Not Applicable		Not Applicable	
Annual Wellness Incentive (Single / Family)	\$500 / \$1,000 Top Life Pledge Required		\$500 / \$1,000 Top Life Pledge Required		\$500 / \$1,000 Top Life Pledge Required	
EMPLOYEE WELLNESS PROGRAM						
Tier I: Online Health Assessment & Biometric Screening	Covered in Full	N/A	Covered in Full	N/A	Covered in Full	N/A
Tier II: Behavioral Modification Programs, Health Challenges, Wellness Activities/Events	Covered in Full	N/A	Covered in Full	N/A	Covered in Full	N/A
PREVENTIVE CARE						
Preventive Care, Women's Preventive Services, Preventive Screenings, Well Adult and Well Baby Services	Covered in Full	30% No deductible	Covered in Full	30% No deductible	Covered in Full	50% No deductible
CONDITION MANAGEMENT						
Health Coach	Covered in Full	N/A	Covered in Full	N/A	Covered in Full	N/A
Condition & Disease Management Services through HealthFitness	Covered in Full	N/A	Covered in Full	N/A	Covered in Full	N/A
TREATMENT						
Deductible (Single / Family)	\$2,700 / \$4,800	\$4,200 / \$8,400	\$1,100 / \$2,200	\$2,200 / \$4,400	\$1,600 / \$3,200	\$3,200 / \$6,400
Inpatient & Outpatient Services	15%*	30%*	15%*	30%*	30%*	50%*
Physician Office Services (non-preventive)	15%*	30%*	15%*	30%*	30%*	50%*
Online Physician Services (Anthem LiveHealth Online)	\$49 before deductible \$7.35 after deductible	N/A	\$49 before deductible \$7.35 after deductible	N/A	\$49 before deductible \$14.70 after deductible	N/A
Diagnostic & Labs	15%*	30%*	15%*	30%*	30%*	50%*
Emergency Room or Urgent Care Visit	15%*	30%*	15%*	30%*	30%*	50%*
Prescription Drugs (same benefits across all plans)	Retail (30 day supply)			Retail & Mail Order (90 day supply)		
	Generic Preferred Brand Non-Preferred & Specialty Drugs		\$10* \$30* 50% coinsurance* (min \$40; max \$140)	Generic Preferred Brand Non-Preferred & Specialty Drugs		\$25* \$75* 45% coinsurance (min \$100; max \$350)
Out-of-Pocket Maximum** (Single / Family)	\$4,700 / \$8,800	\$8,200 / \$16,400	\$3,600 / \$7,200	\$7,200 / \$14,400	\$5,100 / \$10,200	\$10,200/\$20,400

*Coinsurance after deductible

**Includes: deductible, coinsurance and copays for medical and prescription drugs