IN-NETWORK	
DEDUCTIBLE	
Individual / Family	$0
MAXIMUM OUT-OF-POCKET	
Individual / Family	$2,000 / $4,000
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)	
PREVENTIVE CARE	
Adult Preventive Care – Routine Physical Exam, Blood Work, Gynecological Exam, Pap Test, Mammogram, Prostate Specific Antigen (PSA) Test, Colonoscopy, Birth Control Rx, Nutritional Counseling	$0
Child Preventive Care – Routine Physical Exam, Immunizations, Nutritional Counseling	$0
FACILITY VISITS	
Teladoc	$10 copay
Primary Care	$10 copay
Specialist	$10 copay
Urgent Care	$10 copay
Emergency Room	$10 copay if admitted $100 copay if not admitted
Inpatient Hospital (up to 120 days per confinement)	$0
Outpatient Surgery	$0
OUTPATIENT DIAGNOSTIC SERVICES	
X-Ray and Lab Services	$0 after $35 x-ray and lab deductible
CT/PET Scan, MRI	$0 after $35 imaging deductible
OTHER MEDICAL SERVICES	
Hearing Exams	$10 copay
Hearing Aid Benefit (once per 3-year period)	Plan pays up to $1,000
Chiropractic (up to 30 visits per calendar year)	Plan pays up to $25 per visit after $10 copay
Physical Therapy (up to 52 visits per course of treatment)	Visits 1-26: $0 Visits 27-52: Plan pays 80%
Occupational & Speech Therapy (outpatient)	$0
Mental Health Care (outpatient & inpatient, up to 120 days per confinement)	$0
Chemotherapy & Radiation (outpatient)	$0
Emergency Ambulance and Paramedic	Plan pays 80%
PRESCRIPTIONS (Generic and Brand Name)	
Maximum Out-of-Pocket for Prescriptions	$4,600 / $9,200
Preventive Prescription Drugs	Plan pays 80% after copay of $10 - $35
Maintenance Prescription Drugs	Plan pays 80% after copay of $20 - $70