

Cost Summary**Annual Deductible**

	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	\$4,500	\$9,000
Family	\$9,000	\$18,000

Out-of-Pocket Maximum

	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	\$10,600	\$21,200
Family	\$21,200	\$42,400

Coinsurance (After Deductible)

Member Pays	30%	50%
Employer HSA Contribution	N/A - not an HSA plan	50%

Schedule of Benefits

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Professional Services			
Primary Care Physician	No	\$40 Copay	Deductible & Coinsurance
Specialist <i>Includes mental and behavioral health</i>	No	\$75 Copay (per Services table)	Deductible & Coinsurance
Urgent Care	No	\$90 Copay (per Services table)	Deductible & Coinsurance
Other Services Performed in the Office	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Chiropractic Care	No	\$75 Copay (30 visits/plan year)	Deductible & Coinsurance
Therapy — Physical, Speech, Occupational & ABA	No	\$75 Copay (30 visits/plan year)	Deductible & Coinsurance
Telemedicine (through MYMDNOW)	No	\$0 Copay	
Diagnostic Services			
Independent Lab	No	\$25 Copay	Deductible & Coinsurance
X-ray / Radiology	No	\$50 Copay	Deductible & Coinsurance
Advanced Imaging <i>CT / MRI / MRA / Ultrasound / PET Scan</i>	Yes	\$200 Copay	Deductible & Coinsurance
Emergency Services <i>For a true emergency, any provider may be used without penalty or denial</i>			
Emergency Room Facility & Covered Services	No	\$1,000 Copay	Deductible & Coinsurance
Ambulance	No	\$250 Copay (Ground transportation coverage only)	Deductible & Coinsurance
Hospital / Facility Services			
Inpatient Hospital Care Facility	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Associated / Incidental Inpatient Services <i>Anesthesia, pathology, physician services, etc.</i>	Yes	\$250 Copay/Service	Deductible & Coinsurance
Inpatient Hospital Surgical Services	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Rehabilitation / Skilled Nursing Facility	Yes	\$75 Copay/Day (28-day limit/plan year (combined with rehabilitation))	Deductible & Coinsurance
Hospice	Yes	\$0 Copay (30-day limit/lifetime)	\$0 Copay (after deductible)
Organ Transplant	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Services			
Outpatient Surgical Facility <i>Outpatient hospital or ambulatory surgery center</i>	Yes	\$2,500 Copay/Surgery	Deductible & Coinsurance
Outpatient Surgery Services <i>Surgeon, anesthesia, and all associated services</i>	Yes	\$250 Copay/Service	Deductible & Coinsurance
Outpatient Chemotherapy & Radiotherapy <i>Chemotherapy includes infusion only, not oral</i>	Yes	\$250 Copay/Visit	Deductible & Coinsurance

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Dialysis	Yes	\$250 Copay	Deductible & Coinsurance
Preventive Care Services			
Preventive Care <i>Annual wellness exams, labs, and immunizations (see Preventive Care Guide for limits)</i>	No	\$0 Copay /\$0 Deductible	Not Covered
Maternity Services			
Maternity / Childbirth / Delivery	Yes, if exceeds 3 days	\$1,500 Copay/Admission	Deductible & Coinsurance
Maternity Professional Services <i>Routine office visits, lab work, radiology, prenatal and postnatal care</i>	No	Office Visit: \$75 copay Labs: \$25 copay Advanced Imaging: \$200 copay	Deductible & Coinsurance
Other Covered Services			
Home Health Care Visits	Yes	\$50 Copay/Visit (10 visits/plan year)	Deductible & Coinsurance
Durable Medical Equipment (DME)	Yes, \$500 and up	\$50 Copay/Item	Deductible & Coinsurance
Prosthetics	Yes	\$50 Copay/Item (1 item/plan year)	Deductible & Coinsurance
Allergy Testing / Injections	No	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Care — Substance Abuse Detoxification Facility	Yes	Deductible & Coinsurance (5-day limit/plan year)	Deductible & Coinsurance
Inpatient / Partial / Outpatient Treatment for Chemical Use Disorders	Yes	Deductible & Coinsurance (30 day/visit combined limit per plan year)	Deductible & Coinsurance
Nutritional Counseling	No	\$0 Copay (1 visit/plan year)	Deductible & Coinsurance

Pharmacy Benefits

Drug Tier	Prior Auth	Member Pays
Retail Pharmacy — 30-day supply (must be on the plan formulary)		
Preventive Medicine Rx — Generic	No	\$0 Copay
Generic Drugs — Maintenance Rx	No	\$20 Copay
Preferred Brand Name Drugs	No	\$65 Copay
Non-Preferred Brand Name Drugs	Yes	\$95 Copay
Specialty Drugs	Yes	\$200 Copay

Important Notes

1. Failure to obtain required authorization may result in penalties, including a 50% reduction of allowed charges or denial of the claim.
2. In a true emergency (such as a severe injury or life-threatening condition), you may go to the nearest emergency room with no out-of-network penalty or claim denial.
3. If authorization is required following an emergency admission, it must be obtained within 48 hours or by the next business day.