



**In-network Deductible / Coinsurance / Maximums**

<b>In-network deductible and coinsurance</b>	
How it works	Applies to all in-network medical services (except preventive) and prescriptions
Individual	\$10,000 deductible, then 30% pharmacy coinsurance
Family	\$20,000 deductible, then 30% pharmacy coinsurance
<b>In-network out-of-pocket maximum</b>	
How it works	Maximum you pay for deductible and coinsurance
Individual	Not applicable
Family	Not applicable
<b>Maximum plan benefit</b>	
How it works	Maximum amount plan will pay for all in- and out-of-network services
Annual	\$2,000,000 per individual
Lifetime	\$5,000,000 per individual

**Out-of-network Deductible / Coinsurance / Maximums**

<b>Out-of-network medical deductible and coinsurance</b>	
How it works	Applies to out-of-network medical services; emergencies treated as in-network
Individual	\$15,000 deductible, then 50% coinsurance, no out-of-pocket max
Family	\$30,000 deductible, then 50% coinsurance, no out-of-pocket max
<b>Out-of-network out-of-pocket maximum</b>	
How it works	Maximum you pay for deductible and coinsurance
Individual	Not applicable
Family	Not applicable
<b>Maximum plan benefit</b>	
How it works	Maximum amount plan will pay for all in- and out-of-network services
Annual	\$2,000,000 per individual
Lifetime	\$5,000,000 per individual

## Doctor Visits

<b>Primary care office visits</b>	Subject to the \$10,000 individual / \$20,000 family deductible
<b>Specialist office visits</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Physical / occupational therapy visits (30 per year)	
Chiropractor visits	
Pre- and post-natal office visits (office visit copay applies for initial office visit)	
Allergy consultation/testing	
All other specialists	
<b>Services</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Surgical procedures	
Anesthesia	
Diagnostic tests	
Lab tests in a provider's office or freestanding lab	
Imaging tests	
Allergy shot	

## Outpatient Hospital / Facility

<b>Facility services</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Physician services	
Ambulatory surgery	
Anesthesia	
Diagnostic tests	
Lab tests	
Imaging tests	

## Preventive Care

<b>Services</b>	Deductible waived, covered 100% (subject to age limitations and other guidelines)
Annual physical exam	
Routine gynecological services	
Mammography screenings (age 35 and up)	
Prostate cancer screenings	
Adult immunizations	
Well child visits and immunizations (to age 19)	

## Inpatient Hospital / Facility

<b>Facility services</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Physician services	
Pre-admission testing	
Surgery	
Anesthesia	
Maternity delivery	
Diagnostic tests	
Lab tests	
Imaging tests	
Physical rehabilitation (21 days per year)	
Skilled nursing facility (30 days per year)	

## Pharmacy (no out-of-network coverage)

<b>Preventive medications</b>	Deductible waived, then 30% coinsurance
<b>Drug types</b>	Subject to the \$10,000 individual / \$20,000 family deductible, then 30% coinsurance
Generic drugs	
Brand formulary drugs	
Brand non-formulary drugs	
Brand specialty drugs obtained through the pharmacy program	
Mail order prescriptions	

## Treatments and Supplies

<b>Treatments</b>	Subject to the \$10,000 individual / \$20,000 family deductible *Certain specialty drugs are covered only through Accredo, Medco's specialty mail order pharmacy.
Chemotherapy infusion (see Pharmacy section for oral)	
Radiation therapy	
Hemodialysis	
Specialty drugs provided and administered by a health care provider*	
<b>Equipment and Supplies</b>	Subject to the \$10,000 individual/\$20,000 family deductible
Medical supplies	
Durable medical equipment (no out-of-network coverage)	
Prosthetics/orthotics (\$15,000 benefit limit per year)	

## Mental Health

<b>Outpatient</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Mental health visits (30 per year, unless biologically-based)	
<b>Inpatient</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Mental health (30 days per year, unless biologically-based)	

## Chemical Dependency

<b>Outpatient</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Chemical dependency visits (60 per year)	
<b>Inpatient</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Chemical dependency detox (7 days per year)	
Inpatient rehabilitation (30 days per year)	

## Vision

<b>Exams (1 every 2 years)</b>	\$10 copayment per visit (out-of-network varies)
Eye exam	
<b>Eyewear (every 2 years)</b>	\$10 copayment (additional copays for designer frames, specialty lenses, or non-formulary contact lenses; out-of-network varies)
1 pair of glasses OR	
2 boxes of conventional contact lenses OR	
4 boxes of disposable contact lenses	

## Urgent and Emergency Care

<b>Ambulance</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Ambulance and pre-hospital emergency services	
<b>Visits</b>	Subject to the \$10,000 individual / \$20,000 family deductible
Emergency room visit	
Urgent care center visit	