



In-network Deductible / Coinsurance / Maximums

| In-network medical and prescription deductible and coinsurance | |
|---|--|
| How it works | Applies to all in-network medical services (except preventive) and prescriptions |
| Individual | \$5,000 deductible, then 30% pharmacy coinsurance, up to out-of-pocket max |
| Family | \$10,000 deductible, then 30% pharmacy coinsurance, up to out-of-pocket max |
| In-network out-of-pocket maximum | |
| How it works | Maximum you pay for deductible and coinsurance |
| Individual | \$5,950 |
| Family | \$11,900 |
| Maximum plan benefit | |
| 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

| Out-of-network medical deductible and coinsurance | |
|--|---|
| How it works | Applies to out-of-network medical services; emergencies treated as in-network |
| Individual | \$10,000 deductible, then 50% coinsurance, no out-of-pocket max |
| Family | \$20,000 deductible, then 50% coinsurance, no out-of-pocket max |
| Out-of-network out-of-pocket maximum | |
| How it works | Maximum you pay for deductible and coinsurance |
| Individual | Not applicable |
| Family | Not applicable |
| Maximum plan benefit | |
| 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

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|---|--|
| Primary care office visits | Subject to the \$5,000 individual / \$10,000 family deductible |
| Specialist office visits | Subject to the \$5,000 individual / \$10,000 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 | |
| Services | Subject to the \$5,000 individual / \$10,000 family deductible |
| Surgical procedures | |
| Anesthesia | |
| Diagnostic tests | |
| Lab tests in a provider's office or freestanding lab | |
| Imaging tests | |
| Allergy shot | |

Outpatient Hospital / Facility

| | |
|--------------------------|--|
| Facility services | Subject to the \$5,000 individual / \$10,000 family deductible |
| Physician services | |
| Ambulatory surgery | |
| Anesthesia | |
| Diagnostic tests | |
| Lab tests | |
| Imaging tests | |

Preventive Care

| | |
|---|---|
| Services | 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

| | |
|---|--|
| Facility services | Subject to the \$5,000 individual / \$10,000 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)

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|---|---|
| Preventive medications | Deductible waived, then 30% coinsurance (up to \$5,950 individual / \$11,900 family out-of-pocket max) |
| Drug types | |
| Generic drugs | |
| Brand formulary drugs | Subject to the \$5,000 individual / \$10,000 family deductible, then 30% coinsurance (up to \$5,950 / \$11,900 out-of-pocket max) |
| Brand non-formulary drugs | |
| Brand specialty drugs obtained through the pharmacy program | |
| Mail order prescriptions | |

Mental Health

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|---|--|
| Outpatient | |
| Mental health visits (30 per year, unless biologically-based) | Subject to the \$5,000 individual / \$10,000 family deductible |
| Inpatient | |
| Mental health (30 days per year, unless biologically-based) | Subject to the \$5,000 individual / \$10,000 family deductible |

Vision

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

Treatments and Supplies

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|--|--|
| Treatments | |
| Chemotherapy infusion (see Pharmacy section for oral) | Subject to the \$5,000 individual / \$10,000 family deductible *Certain specialty drugs are covered only through Accredo, Medco's specialty mail order pharmacy. |
| Radiation therapy | |
| Hemodialysis | |
| Specialty drugs provided and administered by a health care provider* | |
| Equipment and Supplies | |
| Medical supplies | |
| Durable medical equipment (no out-of-network coverage) | Subject to the \$5,000 individual / \$10,000 family deductible |
| Prosthetics/Orthotics (\$15,000 benefit limit per year) | |

Chemical Dependency

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|---|--|
| Outpatient | |
| Chemical dependency visits (60 visits per year) | Subject to the \$5,000 individual / \$10,000 family deductible |
| Inpatient | |
| Chemical dependency detox (7 days per year) | Subject to the \$5,000 individual / \$10,000 family deductible |
| Inpatient rehabilitation (30 days per year) | |

Urgent and Emergency Care

| | |
|---|---|
| Ambulance | |
| Ambulance and pre-hospital emergency services | Subject to the \$5,000 individual deductible / \$10,000 family deductible |
| Visits | |
| Emergency room visit | Subject to the \$5,000 individual deductible / \$10,000 family deductible |
| Urgent care center visit | |