



In-network Deductible / Coinsurance / Maximums

In-network medical deductible and coinsurance	
How it works	Applies to most facility services and certain treatments (see below for details)
Individual	\$1,500 deductible, then 20% coinsurance, up to out-of-pocket max
Family	Two \$1,500 individual deductibles, then 20% coinsurance, up to out-of-pocket max
In-network out-of-pocket maximum	
How it works	Maximum you pay for deductible and coinsurance
Individual	\$6,000
Family	\$12,000
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 most out-of-network services; emergencies treated as in-network
Individual	\$3,000 deductible, then 50% coinsurance, up to out-of-pocket max
Family	Two \$3,000 individual deductibles, then 50% coinsurance, up to out-of-pocket max
Out-of-network out-of-pocket maximum	
How it works	Maximum you pay for deductible and coinsurance
Individual	\$15,000
Family	\$30,000
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

Primary care office visits	\$25 copayment
Specialist office visits	\$50 copayment (no referrals required for specialists)
Physical / occupational therapy visits (30 per year)	
Chiropractor visits	
Allergy consultation/testing	
All other specialists	
Included services	Included in office visit copayment.
Surgical procedures	
Anesthesia	
Diagnostic tests	
Additional Services	
Lab tests in a provider's office or freestanding lab	\$10 copayment
Imaging tests	20% coinsurance (no out-of-pocket max)
Allergy shot	\$0 copayment

Outpatient Hospital / Facility

Facility services	Subject to the \$1,500 individual deductible (two indiv. deductibles for family coverage), then 20% coinsurance (up to \$6,000 indiv / \$12,000 family out-of-pocket max)
Physician services	
Ambulatory surgery	
Anesthesia	
Diagnostic tests	
Lab tests	
Imaging	
Imaging tests	20% coinsurance (no out-of-pocket max)

Preventive Care

Services	\$0 copayment (subject to age limitations and other guidelines)
Annual physical exam	
Colorectal cancer screenings (age 50-74)	
Routine gynecological services	
Mammography screenings (age 35 and up)	
Prostate cancer screenings	
Adult immunizations	
Well child visits and immunizations (to age 19)	
Pre- and post-natal office visits (office visit copay applies for initial office visit)	

Inpatient Hospital / Facility

Facility services	Subject to the \$1,500 individual deductible (two indiv. deductibles for family coverage), then 20% coinsurance (up to \$6,000 indiv / \$12,000 family out-of-pocket max)
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)

Deductible	\$200 individual deductible
Drug types	
Generic drugs	\$15 copayment
Brand formulary drugs	\$50 copayment
Brand non-formulary drugs	\$100 copayment
Brand specialty drugs obtained through the pharmacy program	\$100 copayment
Mail order prescriptions	3 copayments for a 3-month supply

Mental Health

Outpatient	
Mental health visits (30 per year, unless biologically-based)	\$50 copayment
Inpatient	
Mental health (30 days per year, unless biologically-based)	Subject to the \$1,500 individual deductible (two indiv. deductibles for family coverage), then 20% coinsurance (up to \$6,000 indiv / \$12,000 family out-of-pocket max)

Vision

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

Treatments	
Chemotherapy infusion (see Pharmacy section for oral)	Subject to the \$1,500 individual deductible (two indiv. deductibles for family coverage), then 20% coinsurance (up to \$6,000 indiv / \$12,000 family out-of-pocket max) *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	30% coinsurance (no out-of-pocket max)
Durable medical equipment (no out-of-network coverage)	
Prosthetics/orthotics (\$15,000 benefit limit per year)	

Chemical Dependency

Outpatient	
Chemical dependency visit (60 per year)	\$50 copayment
Inpatient	
Chemical dependency detox (7 days per year)	Subject to the \$1,500 individual deductible (two indiv. deductibles for family coverage), then 20% coinsurance (up to \$6,000 indiv / \$12,000 family out-of-pocket max)
Inpatient rehabilitation (30 days per year)	

Urgent and Emergency Care

Services	
Ambulance and pre-hospital emergency services	Subject to the \$1,500 individual deductible (two indiv. deductibles for family coverage), then 20% coinsurance (up to \$6,000 indiv / \$12,000 family out-of-pocket max)
Visits	
Emergency room visit	\$250 copayment
Urgent care center visit	\$100 copayment