

Medical Plan Highlights

The table below highlights some plan features and cost sharing amounts. For full plan details, please review the plan documents found on the Online Benefits Enrollment portal.

Plan Provision	In-Network Coverage	Out-of-Network Coverage
Annual Deductible	\$1,500 Employee Only \$3,000 Family	Not Covered
Annual Out-of-Pocket Maximum (includes deductible)	\$5,000 Employee Only \$10,000 Family	Not Covered
Preventive Care		
Adult physical examinations & routine pediatric care , including diagnostic tests, immunizations, mammograms, etc.	100%, no deductible	Not Covered
Outpatient Care		
PCP office visit	\$40 Copay	Not Covered
Specialist/Chiropractor	\$50 Copay	Not Covered
Airrosti	\$25 Copay	Not Covered
Outpatient surgery	80% after the deductible	Not Covered
X-ray and lab tests (non-routine MRI, CT, PET, Nuclear Med)	100% first \$1,000 then 80% after deductible	Not Covered
Urgent Care	\$55 Copay	Not Covered
Emergency Room	\$250 Copay + 80% Coinsurance	\$250 Copay + 80% Coinsurance
Outpatient therapy (Visit limit may apply)	\$40 Copay	Not Covered
Inpatient Hospital		
Semi-private room and board	80% after the deductible	Not Covered
Surgical services	80% after the deductible	Not Covered
Prescriptions		
Retail prescriptions: Tier 1	\$5 Copay	Not Covered
Tier 2	\$40 Copay	Not Covered
Tier 3	\$70 Copay	Not Covered
Specialty	\$300 Copay	Not Covered
Mail order prescriptions – 90 Day Supply	2x Retail Copay	Not covered