



SUMMARY OF MEDICAL BENEFITS

****Applies to Medical OOP Maximum**

OOP = Out-of-Pocket

Benefit	<u>\$3,500 HDHP</u>
**Office Visits	Deductible, then Coinsurance
**Teladoc	\$55 Per Visit
**Deductible	\$3,500 (\$7,000 Family)
**Coinsurance	80%/20%
**Prescription Drugs	Deductible, then Coinsurance
Out of Pocket Maximum	<u>In Network:</u> \$5,000 (\$10,000 Family) <u>*Out of Network:</u> \$5,500 (\$11,000 Family)

**Members may be balance billed for Out of Network.*

This comparison of coverages is intended only as a general description of the benefit plans. Please refer to the Benefit Document for details.



SUMMARY OF MEDICAL BENEFITS

Preventive Services	Unlimited Services as Defined by PPACA
In-Hospital Pre-Certification	Deductible + 20% Coinsurance Required for Non-Emergency, Non-Maternity Admissions
Surgery Hospital Inpatient Outpatient	Deductible + 20% Coinsurance
Physician's Office Ambulatory Surgical Center	Covered at 100% of Allowable Charges after Deductible
Laboratory/Pathology/X-Ray	Deductible + 20% Coinsurance
Magnetic Resonance Imaging (MRI)	Deductible + 20% Coinsurance
Work Related Injuries	Deductible + 20% Coinsurance
Therapy Physical Therapy Occupational Therapy Speech Therapy	Deductible + 20% Coinsurance - 30 Combined Visits per Illness or Injury
Spinal Manipulations	Deductible + 20% Coinsurance - 30 Visits per Calendar Year
Ambulance Ground Air	Deductible + 20% Coinsurance
Mental Health	Deductible + 20% Coinsurance
Substance Abuse	Deductible + 20% Coinsurance
Dependent Eligibility	End of Month Age 26
Rehabilitation Services	Deductible + 20% Coinsurance for Specified Conditions that Meet Criteria
Plan Maximum	Unlimited

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