
**SUMMARY OF MEDICAL BENEFITS**

****Applies to Medical OOP Maximum**

**OOP = Out-of-Pocket**

| Benefit | $5,000 HDHP |
|---|---|
| ****Office Visits** | Deductible, then Coinsurance |
| ****Teladoc** | $55 Per Visit |
| ****Deductible** | $5,000 ($10,000 Family) |
| ****Coinsurance** | 80%/20% |
| ****Prescription Drugs** | Deductible, then Coinsurance |
| **Out of Pocket Maximum** | In Network:<br>$6,500 ($13,000 Family)<br><br>*Out of Network:<br>$7,150 ($14,300 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** | Deductible + 20% Coinsurance |
| **Pre-Certification** | Required for Non-Emergency, Non-Maternity Admissions |
| **Surgery** | |
| **Hospital** | |
| **Inpatient** | Deductible + 20% Coinsurance |
| **Outpatient** | |
| **Physician's Office** | Covered at 100% of Allowable Charges after Deductible |
| **Ambulatory Surgical Center** | |
| **Laboratory/Pathology/X-Ray** | Deductible + 20% Coinsurance |
| **Magnetic Resonance Imaging (MRI)** | Deductible + 20% Coinsurance |
| **Work Related Injuries** | Deductible + 20% Coinsurance |
| **Therapy** | |
| **Physical Therapy** | Deductible + 20% Coinsurance - 30 Combined Visits per Illness or Injury |
| **Occupational Therapy** | |
| **Speech Therapy** | |
| **Spinal Manipulations** | Deductible + 20% Coinsurance - 30 Visits per Calendar Year |
| **Ambulance** | |
| **Ground** | Deductible + 20% Coinsurance |
| **Air** | |
| **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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