

SUMMARY OF BENEFITS 2018

Basic Option

Annual Deductible

In-Network: \$1,000 Per Individual/\$3,000 Per Family

Out-of-Network: \$2,000 Per Individual/\$6,000 Per Family

Out of Pocket Maximum

In-Network: \$4,000 Per Individual/\$12,000 Per Family (Includes Deductible)

Out-of-Network: \$10,000 Per Individual /\$25,000 Per Family

Plan's Portion

In-Network: 60%

Out-of-Network: 50%

	In-Network	Out-of-Network	Comments
Primary Care Physician Office Visit/Urgent Care	\$10 co-pay, then paid at 100%	\$2,000 deductible and 50% of eligible expense	Primary Care Physician (PCP) means a Family Practice Physician, General Practitioner, and Internist, Nurse practitioner, Obstetrician/Gynecologist, Pediatrician or Physician's Assistant. All other providers are considered specialists.
Specialist Office Visit	\$15 co-pay, then paid at 100%	\$2,000 deductible and 50% of eligible expense	All other providers not listed above are considered specialists (such as a Cardiologist or Surgeon). For more information refer to the plan document.
Wellness (Routine Care)	\$0 co-pay paid at 100% deductible waived	\$2,000 deductible and 50% of eligible expense	Services include routine physicals and Immunizations. For more information refer to the plan document.
Diagnostic X-ray & Lab	Covered at 100% Deductible waived	\$2,000 deductible and 50% of eligible expense	Includes services performed on an outpatient basis in a physician office, lab facility or hospital (such as blood test and x-ray). For more information refer to plan document.
Advanced Imaging*	\$1,000 deductible and 60% of eligible expense	\$2,000 deductible and 50% of eligible expense	Includes CT scans, MRI, PET scan and nuclear medicine.
Emergency Room	\$150 co-pay then \$1,000 deductible and 60% of eligible expense	\$150 co-pay then \$1,000 deductible & 60% of eligible expense	
Walgreens Take Care & CVS Minute Clinics	\$0 co-pay paid at 100% deductible waived	\$0 co-pay paid at 100% deductible waived	
Retail Prescription	30-day supply: \$0 generic • \$10 preferred brand • \$20 non-preferred • \$100 specialty drug 90-day supply: \$0 generic • \$30 preferred brand • \$60 non-preferred		
Mail Order Prescription (90 Days)	\$0 generic • \$20 preferred brand • \$40 non-preferred		
Vision	Covered at 100% deductible waived	Covered at 100% deductible waived	\$300 annual limit for exams and all related hardware

Dental Benefits

Annual Deductible	\$50 per covered individual
Preventative & Diagnostic	100% no deductible
Basic Services	80% after \$50 deductible
Major Services (Includes Coverage for Dental Implants)	50% after \$50 deductible
Calendar Year Maximum	\$2,000 per covered individual



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