| MEDICAL BENEFITS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Deductible** | $3,000 individual/$6,000 family | $6,000.individual/$12,000 family |
| **Out-of-Pocket Maximum** | $5,000 individual/$10,000 family | $15,000 individual/$30,000 family |
| **Lifetime Maximum Benefit** | Unlimited | |
| **SERVICES RECEIVED AT A PRACTITIONER'S OFFICE** | | |
| **Diagnosis and Treatment of Injury or Illness** | 80% | 60% after deductible |
| **Wellcare Services** | 100% | 60% after deductible |
| **Preventive Care** (Children under 6) | 100% | 60% after deductible |
| **Surgery and Anesthesia*** | 80% after deductible | 60% after deductible |
| **Non-Routine Diagnostic Services** CAT Scans, MRIs, PET Scans, nuclear medicine and other similar technologies | 80% after deductible | 60% after deductible |
| **All Other Diagnostic Services** | 80% after deductible | 60% after deductible |
| **SERVICES RECEIVED AT A FACILITY** | | |
| **Inpatient and Outpatient Hospital Stays and Surgeries*** | 80% after deductible | 60% after deductible |
| **Non-Routine Diagnostic Services** CAT Scans, MRIs, PET Scans, nuclear medicine and other similar technologies | 80% after deductible | 60% after deductible |
| **All Other Diagnostic Services** | 80% after deductible | 60% after deductible |
| **Emergency Room Charges** | 80% after deductible | 80% after deductible |
| **Emergency Non-Routine Diagnostic Services** | 80% after deductible | 80% after deductible |
| **Skilled Nursing or Rehab Facility*** (Limited to 60 days per calendar year) | 80% after deductible | 60% after deductible |
| **BENEFITS FOR OTHER COVERED SERVICES** | | |
| **Ambulance Service** | 80% after deductible | 80% after deductible |
| **Physical, Speech, Occupational and Manipulative Therapy** (Limited to 40 visits per therapy per calendar year) | 80% after deductible | 60% after deductible |
| **Cardiac and Pulmonary Rehab Therapy** (Limited to 36 visits per calendar year) | 80% after deductible | 60% after deductible |
| **Durable Medical Equipment, Orthotics and Prosthetics** | 80% after deductible | 60% after deductible |
| **Supplies** | 80% after deductible | 60% after deductible |
| **Home Health Care*** (Limited to 60 visits per calendar year) | 80% after deductible | 60% after deductible |
| **PHARMACY** | | |
| **Generic Drug** | $3 copay | 60% after deductible |
| **Preferred Brand Drug** | $45 copay | 60% after deductible |
| **Non-Preferred Brand Drug** | $75 copay | 60% after deductible |
| **Special Pharmacy Products** | $150 copay | Not Covered |
| **BEHAVIORAL HEALTH** | | |
| **Inpatient Treatment** | 80% after deductible | 60% after deductible |
| **Outpatient Treatment** | 80% after deductible | 60% after deductible |
| **All expenses will be applied towards the out of pocket** ***may require prior authorization** | | |

| EMPLOYEE MONTHLY DEDUCTIONS | | |
|---|---|---|
| | **Employee Only** | **Employee & Child(ren)** |
| ***Monthly*** | $50.00 | $412.94 |

This plan contains Minimum Essential Coverage that provides Minimum Value under the criteria set forth in the Affordable Care Act. Employees who receive any assistance through the Federal Marketplace may incur a penalty.