



## MEDICAL BENEFITS

POS PLAN	In-Network	Out-of-Network
Calendar Year Deductible (Employee / Employee + Spouse or Child / Family)	Premium—\$500 /\$1,000/ \$1,500  Or Basic— \$1,500 /\$3,000/\$4,500	\$6,000 / \$12,000 / \$18,000
Out-of-Pocket Maximum— Includes Deductible (Employee / Employee + Spouse or Child / Family)	Medical: Premium—\$500 /\$1,000/ \$1,500 Basic— \$1,500 /\$3,000/\$4,500  Pharmacy: Premium—\$500 /\$1,000/ \$1,500 Basic— \$1,500 /\$3,000/\$4,500	\$8,000 / \$16,000 / \$24,000
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	N/A	Member Pays 40% after deductible
Office Visits (PCP / Specialist) Premium Designated Provider (PCP/SPC)	\$25 / \$35 Copay \$15 / \$25 Copay	Member Pays 40% After Deductible
Maternity Physician Services (first visit only)	\$250 Copay	Member Pays 40% After Deductible
Emergency Room Visit (waived if admitted)	\$150 Copay	\$150 Copay
Urgent Care	\$60 Copay	\$60 Copay, Then Deductible
Inpatient Services / Physician Services	\$250 Copay per Admission / Subject to Deductible	Member Pays 40% After Deductible
Outpatient Surgery / Physician Services	\$250 Copay per Admission / Subject to Deductible	Member Pays 40% After Deductible 60% After Deductible
Diagnostic/ X-ray	Subject to Deductible	Member Pays 40% After Deductible
Prescription Drugs-30 days (Tier 1, Tier 2, Tier 3)	\$15 / \$30 / \$60 Copay	Member Pays 40% After Deductible
Mail Order-90 days (Tier 1 , Tier 2, Tier 3)	\$25 / \$60 / \$120 Copay	No Coverage