

Deductible	
Individual	\$2,500
Family	\$5,000
Out of Pocket Maximum	
Individual	N/A
Family	N/A
Plan Benefits	
Preventative & Wellness Office Visit	\$0 Copay
Telemedicine	\$0 Consult Fee
Primary Care Office Visit	\$50 Copay
Specialist Office Visit	\$100 Copay
Laboratory Services - Per Panel Tested	\$100 Copay
Radiology - Per Image Billed	\$60 Copay
CT/MRI/MRA/PET Scans - Per Imaged Billed	\$500 Copay Per Image Billed
Outpatient Services - Limited to Mental & Behavioral Health and Substance Abuse	Specialist Office Visit Copay
Other Outpatient Services	Not Covered
Urgent Care	\$200 Copay
Emergency Room Services	After deductible, \$500 Copay then 50% coinsurance - Limited to 1 visit per plan year
Hospital Inpatient Room & Board Per Admission (includes Mental & Behavioral Health or Substance Abuse)	After deductible, \$500 Copay then 50% coinsurance - Combined limit of 3 days
Preventative Prescriptions Generic Drugs	\$0 Copay (Limited to Preventative Only)
Prescription Benefits - InsuredRx	Preferred Generic = \$0 Copay Formulary Generic = \$10 Copay Formulary Brand Name = \$30 Copay Additional Preferred Brand & Generic = \$50 or Less

NOTE:

Please refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits, the Schedule of Benefits will govern.