

## Option 1

## Option 2

## Option 3

## IN-NETWORK

## DEDUCTIBLE

Individual / Family

\$0

\$0

\$0

## MAXIMUM OUT-OF-POCKET

Individual / Family

\$7,150 / \$14,300

\$7,150 / \$14,300

\$7,150 / \$14,300

## PREVENTIVE CARE

Preventive Care – Annual Well  
Check, Immunizations, and  
Other Related Services

\$0

## FACILITY VISITS

Primary Care

\$15 copay

\$20 copay

\$40 copay

Specialist

\$30 copay

\$40 copay

\$60 copay

Telemedicine – Teladoc

\$0

\$0

\$0

Urgent Care

\$87 copay

\$87 copay

\$140 copay

Emergency Room

\$125 copay

\$125 copay

\$200 copay

Inpatient Hospital

\$100/day

\$150/day

\$500/day

Outpatient Surgery

\$50 copay

\$150 copay

\$500 copay

## OUTPATIENT DIAGNOSTIC SERVICES

X-Ray Services

\$30 copay

\$40 copay

\$60 copay

CT/PET Scan, MRI

\$60 copay

\$120 copay

\$200 copay

## PRESCRIPTIONS

Tier 1 – Generic

\$10 copay

\$10 copay

\$10 copay

Tier 2 – Preferred Brand

\$20 copay

\$40 copay

\$40 copay

Tier 3 – Nonpreferred Brand

\$35 copay

\$70 copay

\$70 copay

## OUT-OF-NETWORK

Refer to Summary of Benefits and Coverage

## BI-WEEKLY COST FOR MEDICAL &amp; PRESCRIPTION COVERAGE

Employee Only

\$61.69

\$42.72

\$18.71

Employee + Spouse

\$436.98

\$396.29

\$342.94

Employee + Child(ren)

\$289.31

\$257.26

\$215.53

Employee + Family

\$629.85

\$568.97

\$500.89