

## Medical Benefits at a Glance

Plan Benefits/Coverage	Active Option	Family Option		Independent Option	
		Adult	Child (Dependent to Age 26)	In-Network	Out-of-Network <sup>1</sup>
Individual Deductible	\$175 Individual \$350 Family	\$175 Individual \$350 Family		\$175 Individual \$350 Family	\$500 Individual \$1,000 Family
Annual-Out-of-Pocket Maximum (includes medical through PHP and pharmacy through Express Scripts)	\$6,350 Individual \$12,700 Family max	\$6,350 Individual \$12,700 Family max		\$6,350 Individual \$12,700 Family max	\$12,700 Individual \$25,400 Family max
Preventive Care <sup>2</sup>	\$0	\$0	\$0	\$0	40%
Primary Care Provider Visit	\$35	\$40	\$10	\$40	40%
Specialist Provider Visit	\$50	\$55	\$40	\$55	40%
Behavioral Health Provider Visit	\$35	\$40	\$10	\$40	40%
Chiropractic and Acupuncture Each limited to 20 visits per plan year	\$50	\$55	\$40	\$55	40%
Outpatient Speech, Physical, and Occupational Therapy Up to 24 visits per year combined	\$50	\$55	\$40	\$55	40%
Colorectal Screening	\$0	\$0	\$0	\$0	40%
Diagnostic Lab and X-Ray	\$0	\$0	\$0	\$0	40%
Imaging and Scanning <sup>3,4</sup>	\$125 PET/MRI \$75 CT scan	\$200 PET/MRI \$125 CT scan	\$100 PET/MRI \$75 CT scan	\$125 PET/MRI \$75 CT scan	40%
Urgent Care <sup>4</sup>	\$35 in network \$35 out network	\$40 in network \$40 out network	\$10 in network \$10 out network	\$45	\$45
Emergency Room Visit <sup>4</sup>	\$200 includes all services and waived if admitted				
Emergency Medical Transportation <sup>4</sup>	\$50 ground/\$100 air				
Hospital Inpatient Stay <sup>3,4</sup> Hospice/Skilled Nursing Care <sup>3,4</sup>	\$500 per admission	\$500 per admission	\$350 per admission	\$500 per admission	40%
Outpatient Surgery <sup>3,4</sup>	20% up to \$500 per visit	20% up to \$500 per visit	20% up to \$200 per visit	20% up to \$500 per visit	40%
Maternity Care – Prenatal and Postnatal	\$35 per visit up to \$200	\$40 per visit up to \$300 <sup>5</sup>		\$40 per visit up to \$300 <sup>5</sup>	40%
Durable Medical Equipment <sup>3,4</sup>	50%				
Gender Reassignment <sup>1,3,4</sup>	Covered. Services payable depending on the type of service received. See above for surgery and office visit costs.				
Home Healthcare	\$0				40%
Unique Service Reimbursement	\$150 per year	\$0 per year		\$250 per year	

**Prescription Drugs - Your prescription benefits are administered by Express Scripts. You can contact Express Scripts at 1-877-860-9256 or [express-scripts.com](http://express-scripts.com)**

<sup>1</sup> Out-of-network benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges. Deductible applies to all out-of-network services.

<sup>2</sup> For a complete list of preventive services, visit [www.healthcare.gov/what-are-my-preventive-care-benefits](http://www.healthcare.gov/what-are-my-preventive-care-benefits).

<sup>3</sup> Prior authorization required.

<sup>4</sup> Subject to annual deductible.

<sup>5</sup> Per pregnancy. Delivery subject to inpatient cost sharing and prior authorization.