$1,500 Deductible - 25% Coinsurance - $25 Copay Plan All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.		
Partial listing of covered services	**Your cost if you visit a:**	
	In-Network provider	**Out-of-Network provider**
Annual Deductible *The amount paid per year before the health plan starts to pay.*	$1,500 per member $4,500 per family	$3,000 per member $9,000 per family
Annual Out-of-Pocket Maximum *The most you pay in a year for health care services covered by your insurance.*	$3,500 per member $7,000 per family	$10,500 per member $21,000 per family
Office visits ● Primary care ● Specialist visits ● Chiropractic care	*The deductible does not apply.* $25 copay/ visit $25 copay/ visit $25 copay/ visit	50% coinsurance 50% coinsurance 50% coinsurance *Chiropractic care is limited to 15 visits per member per year out-of-network.*
Preventive care ● Routine Physical & Eye Exams ● Immunizations & Cancer Screenings ● Well Child Care	*The deductible does not apply.* No charge No charge No charge	50% coinsurance 50% coinsurance 0% coinsurance. Deductible does not apply.
Lab and Pathology	No charge. Deductible does not apply.	50% coinsurance
X-Ray and Other Imaging ● X-rays ● CT, MRI, PET scans	25% coinsurance 25% coinsurance	50% coinsurance 50% coinsurance
Prescription Drugs *Up to a 31-day supply per prescription.*	*The deductible does not apply.* **Generic**: $12 copay/prescription **Preferred brand**: $50 copay/prescription **Non-preferred brand**: $90 copay/prescription	50% coinsurance
Specialty Prescription Drugs *Up to a 31-day supply per prescription received from a designated specialty pharmacy.*	*The deductible does not apply.* **Preferred**: 20% coinsurance **Non-preferred**: 40% coinsurance	Not covered
Outpatient Hospital Services ● Facility ● Physician/surgeon fees	25% coinsurance 25% coinsurance	50% coinsurance 50% coinsurance
Emergency Services ● Emergency room services ● Emergency medical transportation ● Urgent care	25% coinsurance 25% coinsurance $25 copay/ visit. Deductible does not apply.	25% coinsurance 25% coinsurance $25 copay/ visit. Deductible does not apply.
Inpatient Hospital Services ● Facility ● Physician	25% coinsurance 25% coinsurance	50% coinsurance 50% coinsurance

Behavioral Health/Mental Health & Substance Abuse Care ● Outpatient services ● Inpatient hospital services	 $25 copay/ visit. Deductible does not apply. 25% coinsurance	 50% coinsurance 50% coinsurance
Maternity Benefits ● Prenatal care ● Postnatal care ● Delivery & inpatient services	 No charge. Deductible does not apply. No charge. Deductible does not apply. 25% coinsurance	 Prenatal: 0% coinsurance. Deductible does not apply. 50% coinsurance 50% coinsurance
Durable Medical Equipment & Prosthetics	25% coinsurance	50% coinsurance

This health care plan is offered by Medica Insurance Company (MIC). It may not cover all your health care expenses; read your Certificate of Coverage carefully to determine which expenses are covered. This is a benefit summary only and does not outline all of your benefits. If there is a discrepancy between information in this summary and your Certificate of Coverage, the Certificate of Coverage will take precedence in determining your benefits.

This is a high level summary and does not replace your Summary of Benefits and Coverage. Please contact Medica at **1 (800) 952-3455** to obtain further benefit information.

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