

\$3,300 Deductible- 25% Coinsurance - HSA Eligible 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 <i>The amount paid per year before the health plan starts to pay.</i>	\$3,300 per member \$6,600 per family	\$6,600 per member \$13,200 per family
Annual Out-of-Pocket Maximum <i>The most you pay in a year for health care services covered by your insurance.</i>	\$6,500 per member \$13,000 per family	\$19,500 per member \$39,000 per family
Office visits <ul style="list-style-type: none"> ● Primary care ● Specialist visits ● Chiropractic care 	25% coinsurance 25% coinsurance 25% coinsurance 25% coinsurance	50% coinsurance 50% coinsurance 50% coinsurance 50% coinsurance <i>Chiropractic care is limited to 15 visits per member per year out-of-network.</i>
Preventive care <ul style="list-style-type: none"> ● Routine Physical & Eye Exams ● Immunizations & Cancer Screenings ● Well Child Care 	No charge. Deductible does not apply. No charge. Deductible does not apply. No charge. Deductible does not apply.	50% coinsurance 50% coinsurance 0% coinsurance. Deductible does not apply.
Lab and Pathology	25% coinsurance	50% coinsurance
X-Ray and Other Imaging <ul style="list-style-type: none"> ● X-rays ● CT, MRI, PET scans 	25% coinsurance 25% coinsurance	50% coinsurance 50% coinsurance
Prescription Drugs <i>Up to a 31-day supply per prescription.</i>	Generic: 25% coinsurance <i>No charge for preventive drugs.</i> Preferred brand: 25% coinsurance <i>No charge for preventive drugs.</i> Non-preferred brand: 45% coinsurance <i>Preventive drug benefit does not apply.</i>	50% coinsurance
Specialty Prescription Drugs <i>Up to a 31-day supply per prescription received from a designated specialty pharmacy.</i>	Preferred: 25% coinsurance. Member does not pay more than \$200 per prescription unit or refill. Non-preferred: 45% coinsurance	Not covered
Outpatient Hospital Services <ul style="list-style-type: none"> ● Facility ● Physician/surgeon fees 	25% coinsurance 25% coinsurance	50% coinsurance 50% coinsurance
Emergency Services <ul style="list-style-type: none"> ● Emergency room services ● Emergency medical transportation ● Urgent care 	25% coinsurance 25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance 25% coinsurance

Inpatient Hospital Services <ul style="list-style-type: none"> ● Facility ● Physician 	25% coinsurance 25% coinsurance	50% coinsurance 50% coinsurance
Behavioral Health/Mental Health & Substance Abuse Care <ul style="list-style-type: none"> ● Outpatient services ● Inpatient hospital services 	25% coinsurance 25% coinsurance	50% coinsurance 50% coinsurance
Maternity Benefits <ul style="list-style-type: none"> ● Prenatal care ● Postnatal care ● Delivery & inpatient services 	No charge. Deductible does not apply. 25% coinsurance 25% coinsurance	Prenatal: 0% coinsurance. Deductible does not apply. 50% coinsurance 50% coinsurance
Durable Medical Equipment & Prosthetics	25% coinsurance	50% coinsurance
<p>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.</p>		
<p>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.</p>		

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