



BENEFIT	Plan Penny	
	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	Individual: \$3,000 Family: \$6,000	Individual: \$10,000 Family: \$20,000
Out-of-Pocket Maximum	Per Person: \$7,500 Per Family: \$15,000	N/A N/A
Lifetime Maximum	Unlimited	Unlimited
Preventive Care Adult Preventive Care Adult Annual Physical Exam Well-Child Care	covered 100%, no deductible covered 100%, no deductible covered 100%, no deductible	covered 100%, no deductible covered 100%, no deductible covered 100%, no deductible
Outpatient Care Primary care physician office visits Specialist office visits Outpatient surgery Acupuncture (15 visits)	\$20 copay after deductible \$40 copay after deductible 90% after deductible \$40 copay after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible
Diagnostic Procedures Routine Radiology MRI, CT, PET, SPECT Scans etc. Outpatient Laboratory/Pathology	90% after deductible 90% after deductible 90% after deductible	50% after deductible 50% after deductible 50% after deductible
Emergency Care Emergency Room Ambulance when medically necessary Urgent Care	\$125 copay after deductible 90% after deductible \$40 copay after deductible	\$125 copay after deductible 90% after deductible 50% after deductible
Inpatient Hospital	90% after deductible	50% after deductible
Durable Medical Equipment	90% after deductible	50% after deductible
Prescription Drugs <u>Retail Pharmacy (30 day supply)</u> Generic Preferred/Generic Non-Preferred Brand Preferred Brand Non-Preferred	\$7 / \$25 copay after deductible \$55 copay after deductible \$80 copay after deductible	not covered
<u>Mail Order (90 day supply)</u> Generic Preferred/Generic Non-Preferred Brand Preferred Brand Non-Preferred	\$14 / \$50 copay after deductible \$110 copay after deductible \$160 copay after deductible	
<u>Specialty (30 day supply)</u> Generic Preferred/Generic Non-Preferred Brand Preferred Brand Non-Preferred	\$100 / 20% up to \$350 / fill after deductible \$100 after deductible 20% up to \$350 / fill after deductible	
BI-WEEKLY EMPLOYEE CONTRIBUTIONS	Per Pay Cost With Wellness	Per Pay Cost Without Wellness
Employee	\$15	\$25
Employee & Spouse	\$75	\$95
Employee & Child(ren)	\$40	\$50
Family	\$120	\$140

Per Pay Cost with Wellness includes both Employee and Spouse discounts.