	High Deductible Plan	Copay Plan
IN-NETWORK		
ANNUAL DEDUCTIBLE		
Individual / Family	$1,500 / $3,000*	$0
**If enrolled as a family, one member can satisfy the full deductible / out-of-pocket max*		
MAXIMUM OUT-OF-POCKET		
Individual / Family	$6,450 / $12,900*	$6,600 / $13,200*
PREVENTIVE CARE		
Preventive Care – Annual Well Check, Immunizations, and Other Related Services	$0	
FACILITY VISITS		
Primary Care	$0 after deductible	$30 copay
Specialist	$0 after deductible	$50 copay
Telemedicine – Teladoc	$0 after deductible	$0
Urgent Care	$0 after deductible	$87 copay
Emergency Room	$0 after deductible	$125 copay
Inpatient Hospital	$0 after deductible	$250/day
Outpatient Surgery	$0 after deductible	$200 copay
OUTPATIENT DIAGNOSTIC SERVICES		
Lab / Pathology	$0 after deductible	$0
Routine Radiology / Diagnostic Test	$0 after deductible	$50 copay
CT/PET Scan, MRI	$0 after deductible	$75 copay
TAX SAVINGS ACCOUNT	**HSA**	**FSA**
Annual Maximum	$3,650 individual / $7,300 family	$2,500 Medical / $5,000 Dependent
PRESCRIPTIONS		
Tier 1 – Generic	$20 after deductible	$20 copay
Tier 2 – Preferred Brand	$40 after deductible	$40 copay
Tier 3 – Non-Preferred Brand	$70 after deductible	$70 copay
Tier 4 – Specialty**	$125 after deductible	$125 copay
Mail Order	2x retail after deductible	2x retail
OUT-OF-NETWORK	Refer to Summary of Benefits and Coverage	

BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE		
Employee Only	$40.00	$60.00
Employee + Spouse	$325.44	$382.08
Employee + Child(ren)	$237.12	$281.28
Employee + Family	$541.44	$626.88