2019 Plan Year

Dual Option Health Plan Benefits Summary

Benefits Design	Gold Plan - 100/70 IN-NETWORK	Gold Plan - 100/70 OUT-OF-NETWORK	Silver Plan - 80/60 IN-NETWORK	Silver Plan - 80/60 OUT-OF-NETWORK
WELLNESS (Routine Care)				
Physical Exams	$20 Copay; then 100%	70% after Ded.	$30 Copay; then 100%	60% after Ded.
Well Child Care (Including Immunizations)	100%	70% after Ded.	100%	60% after Ded.
Mammogram (Test and Reading)	100%	70% after Ded.	100%	60% after Ded.
Pap Smears (Test and Reading)	100%	70% after Ded.	100%	60% after Ded.
Prostate Blood Test (Test and Reading)	100%	70% after Ded.	100%	60% after Ded.
MAJOR MEDICAL				
Deductible (Ded)	N/A	$500/Individual $1,000/Family	$500/Individual $1,000/Family	$1,000/Individual $2,000/Family
Plan Payment (Coinsurance)	100%	70% after Ded.	80% after Ded.	60% after Ded.
Out-of-Pocket Maximum (including Deductible, Copays & Coinsurance)	$2,500/Individual $5,000/Family	$3,000/Individual $6,000/Family	$4,000/Individual $8,000/Family	$5,000/Individual $10,000/Family
HOSPITAL BENEFITS				
Hospital Deductible	$300 Copay; then 100%	70% after Ded.	$400 Copay; then 80%	60% after Ded.
Out-Patient	$100 Copay; then 100%	70% after Ded.	$100 Copay, then 80%	60% after Ded.
Emergency Room	$100 Copay (Waived If Admitted) Medical Emergency	70% after Ded.	$100 Copay (Waived If Admitted) Medical Emergency	60% after Ded.
Urgent Care	$20 Copay; then 100%	70% after Ded.	$30 Copay, then 80%	60% after Ded.
SURGICAL BENEFITS				
In-Patient	$300 Copay; then 100%	70% after Ded.	$400 Copay; then 80%	60% after Ded.
Out-Patient	$100 Copay; then 100%	70% after Ded.	$100 Copay; then 80%	60% after Ded.
PHYSICIANS OFFICE VISITS (including Specialists)	$20 Copay; then 100%	70% after Ded.	$30 Copay; then 100%	60% after Ded.
TELADOC "OFFICE" VISIT	$40 Copay; then 100%	N/A	$40 copay; then 100%	N/A
DIAGNOSTIC X-RAY & LABORATORY SERVICES	100%	70% after Ded.	100%	60% after Ded.
PRESCRIPTION DRUG CARD (Copay)	$10 Generic $30 Preferred	$10 Generic $30 Preferred	$20 Generic $40 Preferred	$20 Generic $40 Preferred
Mail Order (up to 90 days supply)	$20 Generic $60 Preferred	$20 Generic $60 Preferred	$40 Generic $80 Preferred	$40 Generic $80 Preferred
MENTAL/NERVOUS & SUBSTANCE ABUSE				
In-Patient	$300 Copay; then 100%	70% after Ded.	$400 Copay; then 80%	60% after Ded.
Out-Patient	$100 Copay; then 100%	70% after Ded.	$100 Copay, then 80%	60% after Ded.
ADDITIONAL MEDICAL BENEFITS				
Pre-Admission Testing	100%	70% after Ded.	100%	60% after Ded.
Second Surgical Opinion	100%	70% after Ded.	100%	60% after Ded.
Home Health Care	$20 Copay, then 100% 60 Visits Cal. Yr. Max.	70% after Ded. 60 Visits Cal. Yr. Max.	100% 60 Visits Cal. Yr. Max.	60% after Ded. 60 Visits Cal. Yr. Max.
Extended Care Facility	100% 60 Days Cal. Yr. Max.	70% after Ded. 60 Days Cal. Yr. Max.	100% 60 Days Cal. Yr. Max.	60% after Ded. 60 Days Cal. Yr. Max.
Hospice	100% 180 Days Lifetime Max.	70% after Ded. 180 Days Lifetime Max.	100% 180 Days Lifetime Max.	60% after Ded. 180 Days Lifetime Max.
Birthing Center	$20 Copay, then 100%	70% after Ded.	$30 Copay, then 100%	60% after Ded.
Ambulance Services	100%	70% after Ded.	100%	60% after Ded.
Medical Supplies and Durable Equipment	100%	70% after Ded.	100%	60% after Ded.