

	IN-NETWORK	OUT-OF-NETWORK*
DEDUCTIBLE		
Individual / Family	\$1,000 / \$2,000	\$7,000 / \$14,000
If enrolled as a family, no one family member may contribute more than the individual deductible / out-of-pocket maximum		
PRIMARY CARE PHYSICIAN ELECTION AND REFERRALS REQUIRED		
	No	No
COINSURANCE		
	100%	50% after deductible
MAXIMUM OUT-OF-POCKET		
Individual / Family	\$5,000 / \$10,000	\$10,000 / \$20,000
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)		
PREVENTIVE CARE		
Annual Well Check, Immunizations, and Other Related Services	\$0	50% after deductible
FACILITY VISITS		
Imaging or Procedure through KISx Card	\$0	n/a
Telemedicine (Teladoc)	\$5 copay	n/a
Primary Care	\$20 copay	50% after deductible
Specialist Visits	\$30 copay	50% after deductible
Inpatient Hospital	100% after deductible	50% after deductible
Outpatient Surgery	100% after deductible	50% after deductible
Emergency Room	\$200 copay, waived if admitted	\$200 copay, waived if admitted
Urgent Care	\$75 copay	\$75 copay
Mental Health Visits	\$10 copay	50% after deductible
OUTPATIENT DIAGNOSTIC SERVICES		
X-ray and independent lab	100% after deductible	100% after deductible
Lab (not independent)	\$50 after deductible	50% after deductible
CT/PET Scan, MRI	\$250 copay after deductible	50% after deductible
PRESCRIPTIONS		
Tier 1 – Generic	\$7 copay	n/a
Tier 2 – Preferred Brand	\$55 copay	n/a
Tier 3 – Non-Preferred Brand	\$80 copay	n/a
Mail Order	2x retail	n/a
Tier 4 – Specialty – may require a small manufacturer's copay	Covered at 100%/\$0 Copay	n/a
BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE		
Employee Only	\$45.33	
Employee + Spouse	\$230.38	
Employee + Child(ren)	\$218.93	
Employee + Family	\$303.57	

*Subject to balance billing.