	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 PHYSCIAN ELECTION AND REFERRALS REQUIRED		
	No	No
COINSURANCE		
	100%	50%
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	$0
Telemedicine (Teladoc)	$5 copay	n/a
Primary Care	$20 copay	50% covered
Specialist Visits	$30 copay	50% covered
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
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	$7 copay
Tier 2 – Preferred Brand	$55 copay	$55 copay
Tier 3 – Non-Preferred Brand	$80 copay	$80 copay
Mail Order	2x retail	2x retail
Tier 4 – Specialty**	Covered at 100%/$0 Copay	Covered at 100%/$0 Copay
BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE		
Employee Only	$43.17	
Employee + Spouse	$219.41	
Employee + Child(ren)	$208.50	
Employee + Family	$289.11	

**May require a small manufacturer's copay.