DEDUCTIBLE (Individual | Family)	$0 | $0
OUT OF POCKET MAXIMUM (Individual | Family)	$8,550 | $17,100
PREVENTIVE & WELLNESS SERVICES	$0 Copay (Plan pays 100% of covered preventive and wellness services)
TELEMEDICINE SERVICES	$0 Copay
PRIMARY CARE OFFICE VISIT	$10 Copay
SPECIALIST OFFICE VISIT	$75 Copay
LABORATORY SERVICE & RADIOLOGY	$50 Copay Per Panel Tested/ Per Image Billed
CT/MRI/MRA/PET SCAN	$500 Copay Per Image Billed
URGENT CARE	$25 Copay
OUTPATIENT SERVICES (Limited to Mental & Behavioral Health or Substance Abuse)	$75 Copay
PHARMACY BENEFITS (Subject to Formulary)	Generic - $0 Copay (Limited to Preventive Generic drugs. Plan pays 100% of covered preventive drugs. In addition, a discount pharmacy program is provided that allows other drugs to be obtained at payments ranging from $0 to $50.)
SUPPLEMENTAL HOSPITAL BENEFIT	$5,000 Limited to $1,000 per day; maximum of 5 days of hospitalization or 4 days of hospitalization and 1 emergency room visit.

PLEASE NOTE:

- Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.
- Refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits the Schedule of Benefits will govern.