

# Benefits-at-a-Glance



Medical Plan	
Plan Category	Choice
Plan Code	BG-7T
<b>Plan Basics</b>	
Primary Care Physician Required?	No
Electronic Referrals Required to see Specialists?	No
Out of Network Benefits?	No
Pediatric Dental & Vision	Yes
Medical Deductible Type	Emb
<b>Out of Pocket</b>	
<b>Deductible</b>	
Individual	\$3,000
Family	\$6,000
<b>Out-of-Pocket Maximum</b>	
Individual	\$7,900
Family	\$15,800
Coinsurance	20%
<b>Office Visits</b>	
Office Visits — Primary Care	\$30 first 3 visits (*combined) / DED/Coin
Office Visits — Specialist	\$60 first 3 visits (*combined) / DED/Coin
Virtual Visits	Covered 100%
Preventive Services	Covered 100%
<b>Lab and Diagnostic Services</b>	
Minor Lab Testing and X-ray — Physician Office	DED/Coin
Minor Lab Testing and X-ray — Freestanding Facility	DED/Coin
Minor Lab Testing and X-ray — Hospital	\$250 POD + DED/Coin
Major Diagnostic and Imaging Services - Freestanding Facility	DED/Coin
Major Diagnostic and Imaging Services - Hospital	\$500 POD + DED/Coin
<b>Other Care Options</b>	
Urgent Care	\$30
Emergency Room	\$500 + DED/Coin
Outpatient Services - Freestanding Facility	DED/Coin
Outpatient Services - Hospital	\$500 POD + DED/Coin
Inpatient Hospital	\$500 POD + DED/Coin
Pharmacy Plan	836
<b>Retail</b>	
<b>Deductible</b>	
Individual	No Rx DED
Family	No Rx DED
Tier 1	\$15
Tier 2	\$50
Tier 3	\$135
Tier 4	\$350
<b>Mail Order</b> (Times Retail) Only certain prescription drug products are available through mail order. See your plan documents for details	2.5
<b>Plan Notes</b>	<p>*POD = Per Occurrence Deductible</p> <p>*Avoid paying a POD when you avoid hospitals and receive services at a freestanding facility</p> <p>*Office Visits - Copays only apply to the first 3 PCP or Specialist Visits <b>combined</b>. After the first 3, all subsequent office visits are subject to DED/COIN</p>

This information is a brief, general description of your coverage; it is not a contract and does not replace your Certificate of Coverage/ Summary Plan Description. For a complete list of your coverage, including exclusions and limitations relating to your coverage, please read your Certificate of Coverage/Summary Plan Description. If descriptions, percentages, and dollar amounts conflict with official benefit coverage documents, the official benefits coverage documents prevail.

\*Emb = Embedded Deductible= All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

\*NonEmb = Non-Embedded Deductible = No one in the family is eligible for benefits until the family deductible is met.