

Major Medical Plan Grid



SERVICE	COPAY 3500		COPAY 4500		COPAY 8000		HSA 5000	MVP
	TIER 1 PREFERRED NETWORK	TIER 2 IN-NETWORK	TIER 1 PREFERRED NETWORK	TIER 2 IN-NETWORK	TIER 1 PREFERRED NETWORK	TIER 2 IN-NETWORK	TIER 1 IN-NETWORK	TIER 1 IN-NETWORK
Deductible (Individual / Family)	\$0 / \$O	\$3,500 / \$7,000	\$0 / \$O	\$4,500 / \$9,000	\$0 / \$0	\$8,000 / \$16,000	\$5,000 / \$15,000	\$7,000 / \$14,000
Out Of Pocket Max (Individual / Family)	\$7,000 / \$14,000	\$7,000 / \$14,000	\$8,700 / \$17,400	\$8,700 / \$17,400	\$8,700 / \$17,400	\$8,700 / \$17,400	\$5,000 / \$15,000	\$8,500 / \$17,000
PHYSICIAN SERVICES								
Preventive Care	N/A	\$0	N/A	\$ O	N/A	\$ O	\$0 (Before Ded.)	\$ O
Primary Care Visit	N/A	\$25 Copay	N/A	\$40 Copay	N/A	\$40 Copay	0% (After Ded.)	\$40 Copay
Specialist Care Visit	\$0	\$45 Copay (Office)	\$ O	\$60 Copay (Office)	\$0	\$80 Copay (Office)	0% (After Ded.)	\$60 Copay (Office)
Physical Rehabilitation	\$0	\$45 Copay	\$ O	\$60 Copay	\$0	\$80 Copay	0% (After Ded.)	\$60 Copay (Office)
Mental Health: Outpatient	\$0	\$45 Copay (Office)	\$ O	\$60 Copay (Office)	\$0	\$80 Copay (Office)	0% (After Ded.)	\$35 Copay (Office)
Mental Health: Inpatient	\$0	30% Coinsurance	\$0	20% Coinsurance	\$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
PREVENTIVE CARE								
Routine Adult & Child Care, Immunizations, Cancer Screenings, Mammograms, OB/GYN Visits	N/A	\$0	N/A	\$O	N/A	\$O	\$0 (Before Ded.)	\$O
HOSPITAL SERVICES								
Urgent Care	\$0	\$65 Copay (Office)	\$0	\$70 Copay (Office)	\$0	\$100 Copay (Office)	0% (After Ded.)	\$30 Copay
Diagnostic Test (X-Ray / Blood Work)	\$0	\$50 Copay (Individual Lab)	\$0	\$50 Copay (Individual Lab)	\$0	\$50 Copay (Individual Lab)	0% (After Ded.)	\$60 Copay
Advanced Imaging (CT / MRI / PET)	\$0	30% Coinsurance	\$ O	20% Coinsurance	\$ O	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Emergency Room	N/A	30% Coinsurance	N/A	20% Coinsurance	N/A	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Ambulance	N/A	30% Coinsurance	N/A	20% Coinsurance	N/A	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Hospital Stay	\$0	30% Coinsurance	\$0	20% Coinsurance	\$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Outpatient Procedure	\$0	30% Coinsurance	\$0	20% Coinsurance	\$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Childbirth/Delivery Services	\$0	30% Coinsurance	\$ O	20% Coinsurance	\$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
PRESCRIPTION DRUGS								
Rx Deductible (Ind/Family)	N/A	N/A	N/A	\$250 / \$500**	N/A	\$250 / \$500**	N/A	\$250 / \$500
Rx Tier 1 Generic (30-Day / 90-Day)*	N/A	\$0 / \$0 Copay	N/A	\$0 / \$0 Copay	N/A	\$0 / \$0 Copay	0% (After Ded.)	\$0 / \$0 Copay
Rx Tier 2 Formulary Brand (30-Day / 90-Day)*	N/A	\$35 / \$75 Copay	N/A	\$45 / \$90 Copay	N/A	\$55 / \$110 Copay	0% (After Ded.)	\$55 / \$110 Copay
Rx Tier 3 Non-Formulary Brand (30-Day / 90-Day)*	N/A	\$70 / \$150 Copay	N/A	\$90 / \$180 Copay	N/A	\$100 / \$200 Copay	0% (After Ded.)	\$100 / \$200 Copay
Rx Tier 4: Specialty (30-Day / 90-Day)*	N/A	Contact EHIM	N/A	Contact EHIM	N/A	Contact EHIM	Contact EHIM	Not Covered

^{*}Rx 30-day supply is retail only, 90-day supply is retail or mail order.

Certain services require prior authorization to access benefits or avoid penalty. See your plan documents for more information.

HSA 5000 and MVP Plans are managed care plans & require prior authorization for most services.

Our team will work diligently to find you a Tier 1 provider, however there are instances where no provider is available. Tier 1 benefits are not guaranteed.

Health insurance you can afford!
Scan here...



^{**}Deductible does not apply to generics on Copay 4500 and Copay 8000.