

**BENEFIT FEATURES**

Deductible and Maximum Out-of-Pocket are combined between Tier 1 and Tier 2. Maximum Out-of-Pocket includes any Deductible, Coinsurance, medical Copayments and prescription copay/Coinsurance but does not include non-covered amounts above the Plan's Allowable Charges, or Precertification penalties.

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| Annual Deductible  | None   | \$2,500/Individual; \$5,000/Family (Embedded)                                |
| Annual Maximum Out-of-Pocket   | \$6,000/Individual; \$12,000/Family (Embedded)   | \$8,550/Individual; \$17,100/Family (Embedded)                               |
| Lifetime Maximum   | Unlimited  | Unlimited  |
| <b>Preventive Care/screenings</b>  |  |  |
| Preventive Care (wellness office visit)  | Plan pays 100%   | Plan pays 100%   |
| Preventive Care/screenings   | Plan pays 100%   | Plan pays 100%   |
| <b>Physician services</b>  |  |  |
| Primary Care Provider  | First 2 PCP visits covered at 100%; subsequent visits, You pay \$30 copay/visit (Preventive office visits do not count toward the first 2 PCP office visits covered at 100%) | After Deductible, Plan pays 50%  |
| Non - routine gynecological care   | You pay \$50 copay/visit   | After Deductible, Plan pays 50%  |
| Routine pre-natal care   | You pay \$30 copay (initial visit only)  | After Deductible, Plan pays 50%  |
| Specialist Physician   | You pay \$50 copay/visit   | After Deductible, Plan pays 50%  |
| Walk In clinic   | You pay \$30 copay/visit   | After Deductible, Plan pays 50%  |
| Telehealth services (TelaDoc)  | General Medicine/Behavioral Health:<br>You pay \$30 copay/visit<br>Dermatology: You pay \$50 copay/visit   | N/A  |
| <b>Hospital services</b>   |  |  |
| Inpatient- Facility/Hospital charges <sup>(2)</sup>  | \$500 copay per day up to \$2,500 maximum per admission, then Plan pays 100%   | After Deductible, Plan pays 50%  |
| Outpatient Ambulatory Surgery- Facility/Hospital charges <sup>(2)</sup>  | \$250 copay then plan pays 100%  | After Deductible, Plan pays 50%  |
| All other Outpatient Care- Facility/Hospital charges   | \$50 copay then Plan pays 100%   | After Deductible, Plan pays 50%  |
| <b>Emergency Care</b>  |  |  |
| Urgent Care Center   | You pay \$50 copay/visit   | You pay \$50 copay/visit   |
| Emergency admission  | \$500 copay per day up to \$2,500 maximum per admission, then Plan pays 100%   | \$500 copay per day up to \$2,500 maximum per admission, then Plan pays 100% |
| Emergency room services  | \$100 copay/visit, then Plan pays 100% (Copay waived if admitted)  | \$100 copay/visit, then Plan pays 100% (Copay waived if admitted)            |
| <b>Inpatient Mental Health and Substance Use Disorders<sup>(2)</sup></b>   |  |  |
| - Facility/Hospital based  | \$500 copay per day up to \$2,500 maximum per admission, then Plan pays 100%   | After Deductible, Plan pays 50%  |
| - Physician/professional charges   | Plan pays 100%   | After Deductible, Plan pays 50%  |
| <b>Outpatient Mental Health and Substance Use Disorders</b>  |  |  |
| - Office based   | You pay \$30 copay/visit   | After Deductible, Plan pays 50%  |
| - All other Outpatient (includes: Partial Hospitalization treatment, intensive outpatient program, skilled behavioral health services, electro-convulsive therapy (ECT), transcranial magnetic stimulation (TMS), psychological and neuropsychological testing, 23 hour observation, peer counseling support by a peer support specialist, outpatient and ambulatory detoxification) | You pay \$50 copay/visit   | After Deductible, Plan pays 50%  |
| <b>Laboratory services<sup>(2)</sup></b>   |  |  |
| - Facility/Hospital based  | Plan pays 100%   | After Deductible, Plan pays 50%  |
| - Office based or free-standing lab  | You pay \$30 copay/visit   | After Deductible, Plan pays 50%  |
| <b>Other Diagnostic Services (X-rays/MRIs/CT Scans/PET Scans/MRAs/mammography etc.)<sup>(2)</sup></b>  |  |  |
| - Facility/Hospital based  | Plan pays 100%   | After Deductible, Plan pays 50%  |
| - Office based   | Plan pays 100%   | After Deductible, Plan pays 50%  |
| <b>Outpatient Therapy Services<sup>(2)</sup></b>   |  |  |
| - Facility/Hospital based  | You pay \$50 copay/visit   | After Deductible, Plan pays 50%  |
| - Office based or free-standing  | You pay \$50 copay/visit   | After Deductible, Plan pays 50%  |
| <b>Plan notes/requirements:</b>  |  |  |

Embedded means you can satisfy the Family "Deductible" or the Family "Maximum Out-of-Pocket" with any combination of family members satisfying the amount. However, no one individual may meet more than the individual amount.

For all Out-of-Network elective and Non-Emergent Services, there is no coverage.

(2) Some services listed may require Precertification. Network Providers should obtain Precertification for you. You are responsible for Precertification for all services by Out-of-Network Providers. A penalty of 50% of the Plan's Allowable Charge, to a maximum of \$10,000 will be applied if Precertification is not obtained. See the Plan's website at [www.membershealthplanni.com](http://www.membershealthplanni.com) for a complete Precertification list.

Note: This summary is not intended to be a comprehensive list of services and is not a guarantee of coverage. Once enrolled, you will be supplied with a Plan Document/Summary Plan Description (SPD) that will detail all covered services.