BENEFIT HIGHLIGHTS

COPAY EDGE

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details. The chart below shows the member's share of covered charges.

	Top Preferred Provider	Preferred Provider	Core Provider	Out-of-Network
Annual Deductible	$0 employee only; $0 family			$5,000 employee only; $10,000 family
Annual Out-of-Pocket Maximum	$8,000 employee only; $16,000 family			Unlimited
Preventive Services Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/ office), and Immunizations	No Charge			30% Coinsurance
Primary Care Physician Office Visit	$30	$65	$125	30% Coinsurance
Specialty Care Physician Office Visit	$75	$150	$325	30% Coinsurance
Office Visit/Virtual Visit MDLIVE providers	$25			N/A
Mental Health & Chemical Dependency Office Visit	$30			30% Coinsurance
Outpatient Behavioral Health/ Substance Abuse	$250			30% Coinsurance
Rehabilitation/Habilitation Services Physical, Occupational & Speech Therapy	**Office visit:** $100 **Outpatient facility:** $150 **Inpatient:** $5,800			N/A

IMPORTANT: You are required to use SleepCharge (Nox Sleep Care) for testing/treatment of sleep conditions.

	Top Preferred Provider	Preferred Provider	Core Provider	Out-of-Network
Inpatient Surgery/Stay For inpatient surgery at an in-network facility, you pay one copay per inpatient stay. After the copay, covered services provided by the surgeon, physicians, and other in-network ancillary providers are covered at 100%, with no additional copays for services received during the same stay.	**Inpatient Surgery:** $8,000 **Inpatient Stay:** $5,800			30% Coinsurance
Outpatient Surgery The copay includes most covered services provided as part of outpatient surgery. Prior authorization may be required for non-emergency procedures.	**Office Surgery:** $190 **Freestanding Facility/Ambulatory Surgery Center:** $1,750 **Outpatient Hospital:** $2,500			30% Coinsurance
Ambulance Services Ground and Emergency Air Transport (must be medically necessary)	$815 Ground and $1,190 Air Transport			
Emergency Room Treatment Copayment waived if admitted. Balance billing is not allowed for out-of-network emergency care. No Charge for Covid treatment.	$1,200			
Urgent Care	$150			30% Coinsurance
Diagnostic Lab No charge for COVID tests. Gynecological and obstetrical ultrasounds do not require prior authorization. Most standard diagnostic testing provided during a PCP or specialist office visit is covered under the applicable office visit copay. Prior authorization may be required for other services. See your benefit booklet for details.	$175			30% Coinsurance
Diagnostic Imaging & X-Ray Diagnostic Imaging includes Diagnostic Bone Density and Radioisotope Tests.	$150			30% Coinsurance
IMPORTANT: You are required to use OneImaging for non-emergency/non-urgent MRIs and CTs.*				
MRI*	$200 Freestanding/$535 Outpatient			30% Coinsurance
CT*	$150 Freestanding/$535 Outpatient			30% Coinsurance
PET	$400 Freestanding/$535 Outpatient			30% Coinsurance