Summary of Benefits 3500 Copay

	3500 Copay Major Medical In-Network / Out-of-Network
Deductible Individual Family	$3,500 / $7,000 $7,000 / $14,000
Out-of-Pocket Maximum Individual Family	$7,000 / $14,000 $14,000 / $28,000
Coinsurance (After Deductible)	20% / 50%

Professional Services	**Prior Authorization Required**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out-of-Network)**
Physician Office Services	No	$40 Copay	Deductible & Coinsurance
Specialist (Includes Mental and Behavioral Health)	No	$75 Copay	Deductible & Coinsurance
Urgent Care	No	$90 Copay	Deductible & Coinsurance
Other Services performed in the offices	Yes (Surgery)	20% Coinsurance	Deductible & Coinsurance

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Chiropractic Care 30 Visit Limit per benefit plan year	No	Deductible & Coinsurance	Deductible & Coinsurance
Therapy: Physical, Speech, Occupational, & ABA 30 Visit Limit combined per benefit plan year	Yes, after 12 visits	Deductible & Coinsurance	Deductible & Coinsurance
Telemedicine - through Recuro Health ONLY VIEW MORE DETAILS	No	$0 Copay	$0 Copay
Diagnostic Services	**Prior Auth Req.**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out-of-Network)**
Labs (In Independent Lab)	No	$25 Copay After Deductible	Deductible & Coinsurance
X-Rays	No	$50 Copay After Deductible	Deductible & Coinsurance
Advanced Imaging (Including CT/MRI/MRA/Ultrasound/PET Scan)	Yes	$200 Copay After Deductible	Deductible & Coinsurance

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Emergency Services	Prior Auth Req.	Participating Providers (In-Network)	Non-Participating Providers (Out-of-Network)
Emergency Room Facility and Covered Services Charges *Please note that for a true emergency, any provider may be used without penalty or denial.*	No	Deductible & Coinsurance	Deductible & Coinsurance
Ambulance Ground Transportation Only	No	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient or Partial Hospitalization Services	**Prior Auth Req.**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out-of-Network)**
Inpatient Hospital Care Facility	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Associated / Incidental Inpatient Services (Such as Anesthesia, Pathology, Physician Services, etc.)	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital Surgical Services	Yes	Deductible & Coinsurance	Deductible & Coinsurance

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Inpatient Rehabilitation / Skilled Nursing Facility 28 day limit per benefit plan year	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Hospice 155 day limit per lifetime	Yes	$0 Copay After Deductible	$0 Copay After Deductible
Organ Transplant	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Services	**Prior Auth Req.**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out-of-Network)**
Outpatient Surgical Facility (Outpatient Hospital, Ambulatory Surgery Center)	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery Services (Surgeon, Anesthesia, and any other related services associated with outpatient surgery)	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Chemotherapy, Radiotherapy (Chemotherapy only includes infusion, not oral)	Yes	Deductible & Coinsurance	Deductible & Coinsurance

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Dialysis	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Preventative Care Services	**Prior Auth Req.**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out-of-Network)**
Preventative Care Including, but not limited to Annual Wellness Exams, Lab and Immunizations See Preventative Wellness Guide	No	$0 Copay	$0 Copay / $0 Deductible
Maternity Services	**Prior Auth Req.**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out-of-Network)**
Maternity/ Childbirth/Delivery	Yes, if exceeds standard limits	Deductible & Coinsurance	Deductible & Coinsurance
Maternity Professional Services (Office visits, lab work, radiology, prenatal, postnatal care, etc.)	No	Deductible & Coinsurance	Deductible & Coinsurance
Other Covered Services	**Prior Auth Req.**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out-of-Network)**
Home Health Care Visits 60-day limit per benefit plan year	Yes	Deductible & Coinsurance	Deductible & Coinsurance

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Durable Medical Equipment (DME)	Yes, $750 & Up	Deductible & Coinsurance	Deductible & Coinsurance
Prosthetics 1 item limit per benefit plan year	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Allergy Testing/Injections	No	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Care Substance Abuse Detoxification Facility 5 day limit per benefit plan year	Yes	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient/Partial/ Outpatient Treatment for Chemical Use Disorders 30 day limit per benefit plan year	Yes	Deductible & Coinsurance	Deductible & Coinsurance

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Pharmacy Services	All Rx/Medicine Must be on the Formulary List Plan covers 30-day Supply Only
Deductible	N/A
Generic	$20 Copay
Preferred Brand Drugs	$65 Copay
Non-Preferred Drugs / Specialty Prior Auth Required	$95 / $200 Copay

Notes:

1. Failure to obtain required authorization may result in penalties, including a 50% reduction of allowed charges or denial of the claim.
2. In a true emergency (such as a severe injury or life-threatening condition), you may go to the nearest emergency room with no out-of-network penalty or claim denial.
3. If authorization is required following an emergency admission, it must be obtained within 48 hours or by the next business day.