



Explore Your Benefits

Primary Care Copayment	\$15	\$15	\$15	\$15	\$5	\$20	\$5	\$20
Specialist Care Copayment	\$30	\$30	\$30	\$30	\$20	\$35	\$20	\$35
Emergency Room Copayment	\$150 ²	\$150 ²	\$100	\$100	\$100	\$100	\$100	\$100
In-Network Deductible	\$100 ³ (if hired after 7/1/19)	\$100 ³ (if hired after 7/1/19)	\$100 for Durable Medical Equipment	\$100 for Durable Medical Equipment	None	\$1,500 ⁴	None	\$1,500 ⁴
In-Network Coinsurance	10% ⁵	10% ⁵	0%	0%	None	20%	None	20%
In-Network Coinsurance Maximum (Individual/Family)	\$800/\$2,000	\$800/\$2,000			None	None	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	\$7,360/\$14,720	\$7,360/\$14,720	\$7,360/\$14,720	\$7,360/\$14,720	\$2,500 ⁴	\$4,500 ⁴	\$2,500 ⁴	\$4,500 ⁴
Out-of-Network Deductible (Individual/Family)	\$400/\$1,000	\$400/\$1,000						
Out-of-Network Coinsurance ⁶	30%	30%						
Out-of-Network Out-of-Pocket Maximum (Individual/Family) ⁷	\$2,000/\$5,000	\$2,000/\$5,000						
Out-of-Network Inpatient Hospital Deductible	\$500/stay	\$500/stay						



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