2023 COPPER PLAN

	In-Network	Out-of-Network
Deductible (per calendar year)	$4,000 Individual	$8,000 Individual
	$8,000 Family	$16,000 Family
Coinsurance	50%	50%
Out-Of-Pocket Maximum (includes deductible: excludes all copays and penalty amounts)	$6,350 Individual $12,700 Family	$12,700 Individual $25,400 Family
Preventive Care Services		
Adult Routine Physical Exam (every 24 months), Annual Routine Mammogram, GYN Exam and PSA.	No Charge	Not Covered
Routine Eye and Hearing Screening (one exam every 24 months)	Not covered	Not covered
Physician Services		
Primary Doctor Office Visit	50% co-insurance after deductible	50% co-insurance after deductible
Specialist Office Visits	50% co-insurance after deductible	50% co-insurance after deductible
X-ray and Lab Services (during office visit)	No Charge	Not Covered
Emergency Services		
Emergency Room (copay waived if admitted)	50% co-insurance	50% co-insurance
Urgent Care		
Immediate Medical Attention	50% co-insurance	50% co-insurance
Hospital Services		
Hospital Admission	50% co-insurance after deductible	50% co-insurance after deductible
Outpatient Hospital	50% co-insurance after deductible	50% co-insurance after deductible
Alternatives to Hospital Care		
Skilled Nursing (max. 120 days), this is facility benefit and covered	50% co-insurance after deductible	50% co-insurance after deductible
Home Health (max. 120 days) and Urgent Care	50% co-insurance after deductible	50% co-insurance after deductible
Other Services		
Outpatient Short-Term Rehabilitation (includes speech, physical, occupational and spinal manipulation therapy), in office setting.	50% co- insurance after deductible	Applied behavioral analysis treatment for Autism — by behavioral analyst, up to 18 pre- authorization
HCTC-Eligible and Non-HCTC Plan Options		
Prescription Drug Plan—Retail Pharmacy		
Generic	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Preferred Brand-Name Drugs	After deductible, 50% co-pay ofapproved amount	After deductible, co-pay plus 20% of approved amount
Non-Preferred Brand-Name Drugs	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Prescription Drug Plan—Mail Order (90 Day Supply)		
Generic	50% co-pay of amount	Not covered
Preferred Brand	50% co-pay of amount	Not covered
Non-Preferred Brand	50% co-pay of amount	Not covered

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