Medical Plans

SUMMARY OF COVERED BENEFITS	$5000 Plan	$3000 Plan	$2000 Plan	$1000 Plan
	In-Network	In-Network	In-Network	In-Network
Calendar Year Deductible (Individual / Family)	$5,000 / $10,000	$3,000 / $6,000	$2,000 / $6,000	$1,000 / $3,000
Member Coinsurance	10%	30%	30%	20%
Calendar Year Out of Pocket Maximum (Individual / Family) *(Includes deductible, copays & coinsurance)*	$6,250 / $12,500	$6,250 / $12,500	$6,250 / $12,500	$4,000 / $8000
HSA Eligible	Yes	No	No	No
Preventive Care	No copay	No copay	No copay	No copay
Physician Services - Primary Specialist Urgent Care Teladoc (tele-medicine)	Deductible then 10% Coinsurance	No copay / $50 $50 / $100 No copay No copay	No copay / $50 $50 / $100 No copay No copay	No copay / $50 $50 / $100 No copay No copay
Lab / X-Ray Diagnostic: Lab / X-Ray Complex Imaging (MRI, CT, PET)	Deductible then 10% Coinsurance	$25 copay $400 copay	$25 copay $400 copay	$25 copay $400 copay
Hospital Services In-Patient Out-Patient	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 20% Coinsurance
Emergency Care Ambulance, Accidental Dental, Emergency Room	Deductible then 10% Coinsurance	30% Coinsurance $250 copay, then 30%	30% Coinsurance $250 copay, then 30%	20% Coinsurance $250 copay, then 20%
Maternity Care	Depends on where healthcare service is provided	Depends on where healthcare service is provided	Depends on where healthcare service is provided	Depends on where healthcare service is provided
Mental Health Care In-Patient / Partial Hospitalization Out-Patient	Deductible then 10% Coinsurance	Deductible then 30% No copay	Deductible then 30% No copay	Deductible then 20% No copay
Recovery / Special Care Home Health Rehabilitation Services Habilitation Services Skilled Nursing Care Durable Medical Equipment Hospice Services *(Limitations can apply to the above services)*	Deductible then 10% Coinsurance	30% Coinsurance $50 copay 30% Coinsurance 30% Coinsurance 30% Coinsurance 30% Coinsurance	30% Coinsurance $50 copay 30% Coinsurance 30% Coinsurance 30% Coinsurance 30% Coinsurance	20% Coinsurance $50 copay 20% Coinsurance 20% Coinsurance 20% Coinsurance 20% Coinsurance
Prescription Drugs Tier 1 Tier 2 Tier 3 Mail Order	After Medical Deductible is Met $10 $35 $70 $25 / $87.50 / $175	No Deductible $10 $50 $100 $25 / $125 / $250	No Deductible $10 $50 $100 $25 / $125 / $250	No Deductible $10 $35 $70 $25 / $87.50 / $175
Payroll Deductions (Per 24 Pay Periods) Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	 $0.00 $252.15 $148.33 $243.51	 $33.71 $364.88 $251.97 $400.23	 $47.09 $394.73 $279.41 $441.73	 $88.39 $486.83 $364.07 $569.76

Benefits Contact

NFP, Benefits Management
P: (877) 504-6093
E: assetbenefits@nfp.com