\$279.58

\$230.83

\$388.61

IN-NETWORK - Allied		
DEDUCTIBLE		
Individual / Family	\$3,000 / \$6,000*	\$1,500 / \$3,000*
*If enrolled as a family, each covered member only needs to satisfy their		
individual deductible / out-of-pocket max		
MAXIMUM OUT-OF-POCKET		
Individual / Family	\$5,000 / \$10,000*	\$3,000 / \$6,000*
PREVENTIVE CARE		
Preventive Care - Annual Well Check, Immunizations, and Other Related Services	\$0	
Diabetic Medications - Select Diagnostic Products, Antidiabetics, and Medical Devices	\$0	
FACILITY VISITS		
Teladoc	You pay \$0 after deductible	\$0
Primary Care	You pay 15% after deductible	\$30 copay
Specialist Visits	You pay 15% after deductible	\$50 copay
Inpatient Hospital	You pay 15% after deductible	\$250 copay per day; 5-day max.
Outpatient Surgery	You pay 15% after deductible	You pay 5% after deductible
Emergency Room	You pay 15% after deductible	\$250 copay, waived if admitted
Urgent Care	You pay 15% after deductible	\$50 Copay
Imaging or Procedure through KISx Card	You pay \$0 after deductible	\$0
OUTPATIENT DIAGNOSTIC SERVICES (Freestanding)		
X-Ray Services	You pay 15% after deductible	\$50 copay
CT/PET Scan, MRI	You pay 15% after deductible	US Imaging: \$0 Other Provider: \$200 copay
PRESCRIPTIONS		
Maximum Out-of-Pocket for Prescriptions	Combined with medical	\$1,000 / \$2,000
Rx Deductible - Retail	Combined with medical	\$100 per family unit
Tier 1 - Generic	You pay \$15 after deductible	You pay \$15 after deductible
Tier 2 - Preferred	You pay \$35 after deductible	You pay \$35 after deductible
Tier 3 - Nonpreferred	You pay \$60 after deductible	You pay \$60 after deductible
Specialty - Administered by PaydHealth	You pay 20% or \$250 after deductible, whichever is greater	You pay 20% or \$250, whichever is greater
OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage		
BI-WEEKLY COST FOR MEDICAL, VISI	ON & PRESCRIPTION COVERAC	JE
Team Member Only	\$66.30	\$117.85

Successful completion of the Passport to Health Wellness Program allows you to save \$38.46 per pay (\$1,000 per year) on your medical, vision & prescription coverage.

\$163.90

\$130.71

\$231.43

Team Member + Spouse

Team Member + Family

Team Member + Child(ren)