

**2020 Medical Health Insurance Plans
Personal Choice vs High Deductible Health Plan**

	January 1, 2020 Plan	January 1, 2020 Plan
Plan Benefits	Personal Choice \$20/\$40/\$250	High Deductible Health Plan \$3,000/100%
Deductible: Single/Family	N/A	\$3,000 / \$6,000
In-Network Co insurance	N/A	N/A
Out of Network Benefits	50% after \$2,500/5,000 Ded	50% after \$5,000/10,000 Ded
In-Network Out-of-Pocket Max: S/F	\$7,900 / \$15,800	\$6,750 / \$13,500
Lifetime Benefits Maximum	Unlimited	Unlimited
PHYSICIAN VISIT		
Primary Care Physician/ Routine Physical	\$20 Copay / \$0 Copay	100% after Ded / \$0 Copay
Specialist Visits	\$40 Copay	Covered 100% after Deductible
Routine GYN Visit	\$0 Copay, 1 visit per yr	\$0 Copay, 1 visit per yr
Chiropractic	\$40 Copay, 20 visits per yr	100% after Ded, 20 visits per yr
Speech Therapy	\$40 Copay, 20 visits per yr	100% after Ded, 20 visits per yr
Physical, Occupational Therapy	\$40 Copay, 30 visits per yr	100% after Ded, 30 visits per yr
INPATIENT BENEFITS		
Hospital Room	\$250/day, \$1,250 max	Covered 100% after Deductible
OUTPATIENT BENEFITS		
Surgery (Surg. Center/ Hospital-Based)	\$250 Copay	Covered 100% after Deductible
Routine Colonoscopy (Preventive Plus Providers)	\$0 Copay	\$0 Copay
Routine Colonoscopy (Hospital-Based) ACP will reimburse you \$650 with receipt of invoice	\$750 Copay	\$750 Copay
Laboratory (Freestanding/ Hospital-Based)	\$0 Copay / \$80 Copay	100% after Ded / 90% after Ded
X-Ray, MRI	\$40 Copay / \$80 Copay	Covered 100% after Deductible
Urgent Care / Emergency Room	\$85 Copay / \$250 Copay	Covered 100% after Deductible
MENTAL HEALTH/ SUBSTANCE ABUSE		
Inpatient Mental Health	\$250/day, \$1,250 max	Covered 100% after Deductible
Out Patient Mental Health	\$40 Copay	Covered 100% after Deductible
Inpatient Substance Abuse	\$250/day, \$1,250 max	Covered 100% after Deductible
Out patient Substance Abuse	\$40 Copay	Covered 100% after Deductible
PRESCRIPTION DRUG		
Prescription Deductible: Single	N/A	Integrated
Preferred Generic Copay	\$5 Copay	\$5 Copay after Deductible
Generic Formulary Copay	\$20 Copay	\$20 Copay after Deductible
Brand Formulary Copay	\$40 Copay	\$40 Copay after Deductible
Non-Formulary Copay	\$60 Copay	\$70 Copay after Deductible
Specialty Drugs	50% up to \$500 max	50% up to \$500 max after Ded

NOTE: This is a summary of benefits. Refer to the Summary of Benefits and Coverages (SBC) for a complete description of covered services, limitations and exclusions.