Milton Park Partners Plan Year 8/1/2021 to 7/31/2022

Medical Plan Options	NEW OPTION #1		NEW OPTION #2		NEW OPTION #3		NEW OPTION #4		NEW OPTION #5	
Carrier	Anthem Blue Cross and Blue Shield		Anthem Blue Cross and Blue Shield		Anthem Blue Cross and Blue Shield		Anthem Blue Cross and Blue Shield		Anthem Blue Cross and Blue Shield	
Network	Anthem Blue Open Access POS		Anthem Blue Open Access POS		Anthem Blue Open Access POS		Anthem Blue Open Access POS		Anthem Blue Open Access POS	
Policy Number	OAP5 500/20%/4000 KE		OAP5 3000/0%/8150 KE		HSAOAP3 4000/0%/4000 (H.S.A.)		HSAOAP3 6000/0%/6000 (H.S.A.)		OAP5 5000/0%/8150 KE	
Annual Deductible	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Individual	$500	$5,000	$3,000	$10,000	$4,000	$10,000	$6,000	$15,000	$5,000	$10,000
Family	$1,000	$10,000	$6,000	$20,000	$8,000	$20,000	$12,000	$30,000	$10,000	$20,000
Annual Out of Pocket	Includes Deductible		Includes Deductible		Includes Deductible		Includes Deductible		Includes Deductible	
Individual	$4,000	$10,000	$8,150	$15,000	$4,000	$15,000	$6,000	$20,000	$8,150	$15,000
Family	$8,000	$20,000	$16,300	$30,000	$8,000	$30,000	$12,000	$40,000	$16,300	$30,000
Co-Insurance	20%	40%	0%	30%	0%	30%	0%	50%	0%	30%
Lifetime Max Benefit	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Physician Office Visit	Physician Office Visit		Physician Office Visit		Physician Office Visit		Physician Office Visit		Physician Office Visit	
Virtual visits (Telehealth)	No Charge by a Designated Virtual Network Provider	Not Applicable	No Charge by a Designated Virtual Network Provider	Not Applicable	0% coinsurance	Not Applicable	0% coinsurance	Not Applicable	No Charge by a Designated Virtual Network Provider	30% co insurance after deductible is met
Primary Care	$25 copay/visit; deductible does not apply	40% coinsurance	$25 copay/visit; deductible does not apply	30% coinsurance	0% coinsurance	30% coinsurance	0% coinsurance	50% coinsurance	$25 copay/visit; deductible does not apply	30% coinsurance after deductible is met
Specialist	$50 copay/visit ****	40% coinsurance	$50 copay/visit ****	30% coinsurance	0% coinsurance	30% coinsurance	0% coinsurance	50% coinsurance	$50 copay/visit ****	30% coinsurance after deductible is met
Preventive Care/ Screening/Immmunization	No Charge	40% coinsurance	No Charge	30% coinsurance	no charge	30% coinsurance	No Charge	50% coinsurance	no charge	30% coinsurance after deductible is met
Lab/ Diagnostic	Lab/ Diagnostic		Lab/ Diagnostic		Lab/ Diagnostic		Lab/ Diagnostic		Lab/ Diagnostic	
Diagnostic Services / Lab	Office - $25 PCP / $50 Spec. Freestanding Lab -	40% coinsurance	Office - $25 PCP / $50 Spec. Freestanding Lab - No	30% coinsurance	0% coinsurance	30% coinsurance - preauthorization required**	0% coinsurance	50% coinsurance	Office - $25 PCP / $50 Spec. Freestanding Lab - No	30% coinsurance after deductible is met
X-Ray	Office - $25 PCP / $50 Spec. Radiology-20% Coins. / Out-$500/20% coins		Office - $25 PCP / $50 Spec. Radiology- N/C Outpatient-0% after deductible		0% coinsurance	30% coinsurance - preauthorization required**	0% coinsurance		Office - $25 PCP / $50 Spec. Radiology & Outpatient -0% after deductible	
Imaging (CT/PET scans, MRIs)	Free Standing/Office and Hospital: 20% coinsurance + $500 Hosp-based/cccurrence ***		0% coinsurance after deductible is met		0% coinsurance	30% coinsurance - preauthorization required**	0% coinsurance		0% coinsurance after deductible is met	
Hospital Charge	Hospital Charge		Hospital Charge		Hospital Charge		Hospital Charge		Hospital Charge	
In-Patient (IP) Ded. & Co Ins. (D&C)	20% coinsurance	40% coinsurance**	$1,000 copay/day up to a max $3,000	30% coinsurance**	0% coinsurance after Ded.	30% coinsurance**	0% coinsurance	50% coinsurance	$2,500 copay per day up to max of $7,500 per admission	30% coinsurance**
In-Patient Physician	20% coinsurance	40% coinsurance**	0% coinsurance after Ded.	30% coinsurance**	0% coinsurance after Ded.	30% coinsurance**	0% coinsurance	50% coinsurance	0% coinsurance after Ded.	30% coinsurance**
Out-Patient Surgery - Hospital	$500 copay / 20% coinsurance	40% coinsurance**	0% coinsurance after Ded.	30% coinsurance**	0% coinsurance after Ded.	30% coinsurance**	$500 / 0% coinsurance	50% coinsurance	0% coinsurance after Ded.	30% coinsurance**
Out-Patient Surgery - Freestanding Center	$150 copay - deductible does not apply		$350 per visit		0% coinsurance after Ded.		0% coinsurance after Ded.		$500 copay per visit Deductible does not apply	
Out-Patient Physician	20% coinsurance	40% coinsurance**	0% coinsurance after Ded.	30% coinsurance**	ER 0% coinsurance after Ded.	30% coinsurance**	0% coinsurance	50% coinsurance	0% coinsurance after Ded.	30% coinsurance**
Emergency (ER)	ER $500 copay/visit - deductible does not apply		$500 Copay - deductible does not apply		ER = 0% coinsurance after Ded.		ER 0% coinsurance after Ded.		ER $500 copay per visit - deductible does not apply	
Urgent Care (UC)	UC =$50 copay per visit, ded. does not apply	40% coinsurance *****	UC =$50 copay per visit, ded. does not apply	30% coinsurance *****	UC =0% coinsurance after deductible	30% coinsurance *****	0% coinsurance	50% coinsurance	UC =$50 copay per visit, ded. does not apply	30% coinsurance
Rx Deductible	$200 Individual / $400 Family RX Deductible		$200 Individual / $400 Family RX Deductible		Combined with Medical Deductible		Combined with Medical Deductible		$200 Individual / $400 Family RX Deductible	
RX - Tier I/Tier II/Tier III/TierIIII	$10 / $45 / $85 / $125		$10 / $45 / $85 / $125		0% coinsurance after Deductible is met		0% coinsurance after Deductible is met		$10 / $45 / $85 / $125	
RX - Mail Order (90 Day Supply)	2.5 x Retail ****		2.5 x Retail ****		2.5 x Retail ****		2.5 x Retail ****		2.5 x Retail ****	
RATES	New Rate		New Rate		New Rate		New Rate		New Rate	
Employee Only	$861.45		$613.83		$596.27		$551.62		$575.41	
Employee + Spouse	$1,809.04		$1,289.02		$1,252.15		$1,158.40		$1,208.33	
Employee + Child(ren)	$1,636.75		$1,166.29		$1,132.92		$1,048.08		$1,093.29	
Employee + Family	$2,584.34		$1,841.49		$1,788.80		$1,654.86		$1,726.21	

*** Deductible/coinsurance may not apply to certain services; You may have to pay for services that aren't preventative.**

**** Preauthorization required for out of network for certain services or benefit reduces to 50% of allowed**

***** $500 Hospital-Based per occurrence deductible applies prior to the overall deductible.**

******Preferred 90 Day Retail Network Pharmacy. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.**

******* If you receive services in addition to office visit, urgent care visit, additional copays, deductibles, or coinsurance may apply (e.g. surgery)**