Teammate Benefits Plans

IN-NETWORK MEDICAL BENEFITS	Blue Plan	Bronze Plan		
Network	PHCS	Cigna		
Calendar Year Deductible (Individual / Family)	$0/$0	$3,000 / $6,000		
Maximum Calendar Year Out of Pocket (Individual / Family)	N / A	$6,000 / $12,000		
PROFESSIONAL SERVICES	YOUR RESPONSIBILITY IS:	YOUR RESPONSIBILITY IS:		
Primary Care Visits	$5 Copay, first 2 visits, $25 Copay, visits 3 to 6	$5 Copay, first 2 visits, $25 Copay, visits 3+		
Specialist Visits	$50 Copay, up to 4 visits per year	$50 Copay		
Urgent Care	$25 Copay, up to 4 visits per year	$50 Copay		
Preventative Services	Covered 100%	Covered 100%		
Teledoctor	$0 Copay	$0 Copay		
	FIXED DOLLAR REIMBURSEMENT			
X-RAY / LAB	PLAN WILL COVER UP TO:	YOUR RESPONSIBILITY IS:		
X-ray Services	$500 up to 3 per year	Deductible then 20%		
Laboratory Services	$200 up to 8 per year	Deductible then 20%		
Magnetic Resonance Imaging (MRI)	$1,600 up to 1 per year	Deductible then 20%		
Computerized Tomography (CT) Scan	$1,500 up to 1 per year	Deductible then 20%		
INPATIENT/OUTPATIENT BENEFITS	PLAN WILL COVER UP TO:	YOUR RESPONSIBILITY IS:		
Inpatient Hospital Services, Including Childbirth	$3,000 up to 3 days	Deductible then 20%		
Outpatient Surgery	$1,000 up to 2 per year	Deductible then 20%		
Anesthesia Services	$2,000 up to 5 per year	Deductible then 20%		
Mental Health Benefit	$250 up to 12 per year	Deductible then 20%		
Alcohol and Substance Abuse Benefit	$250 up to 12 per year	Deductible then 20%		
Inpatient / Outpatient Doctor Benefit	$125 up to 10 per year	Deductible then 20%		
EMERGENCY ROOM VISIT	PLAN WILL COVER UP TO:	PLAN WILL COVER UP TO:		
Treatment of an Accidental Injury	$500 up to 2 per year	$500 Copay then Deductible + 20%		
Treatment of a Sickness	$50 up to 1 per year	N / A		
PRESCRIPTION DRUGS	YOUR RESPONSIBILITY IS:	Retail (30 days)	Mail Order (90 days	
Generic	$5 Copay	$15 Copay	$30 Copay	
Preferred Brand	N / A	30%, minimum $35	30%, minimum $70	
Non-Preferred Brand	N / A	40%, minimum $70	40%, minimum $150	
PLAN RATES	Teammate Weekly Cost	Payrate: $10 - $14.99	Payrate: $15 - $16.99	Payrate: $17+
Teammate Only	$17.82	$27.36	$41.04	$46.51
Teammate & Spouse	$46.38	$140.01	$153.69	$159.16
Teammate & Children	$56.46	$112.78	$126.46	$131.93
Family	$80.69	$258.93	$272.61	$278.08

The benefits outlined here are for **IN NETWORK benefits only**. **You MUST be sure to confirm the provider or facility you choose participates in the network before you visit.** The MEC plan does not cover out of network providers or facilities. **If you choose to use an out of network provider you will be responsible for the full cost of the service or visit.**

Finding a Provider

- Visit www.multiplan.com
- Click “Find a Provider” in the top right
- Click “Select Network”
- Select “PHCS”
- Select “Limited Benefit Plan”
- Search for a provider for your desired zip code

For assistance with any benefits questions, claims, and billing inquiries, please call the **Teammate Benefits Line** at: 1-833-236-7463