

RBA 2020 COPAY PLAN

IMPORTANT – THIS DOCUMENT IS FOR GENERAL COMPARISON PURPOSES ONLY FOR DETAILED INFORMATION, REFER TO YOUR SUMMARY PLAN DESCRIPTION

	COPAY PLAN	
Benefit	In-Network	Out-of-Network
Annual Deductible	\$500 / individual \$1,000 / family	\$15,000 / individual \$30,000 / family
HRA / HSA Compatibility	None	
Annual Out-of-Pocket Maximum (includes deductible and copays)	\$6,750 / individual \$13,500 / family	\$19,650 / individual \$39,300 / family
Co-Insurance (Plan Pays)	100%	50%
Lifetime Maximum	Unlimited	

HOSPITAL CARE

Inpatient Hospital – Facility Fee	Deductible then \$2,500 copay per admission	50% after deductible
Inpatient Hospital – Physicians Fees	Deductible then \$500 copay per physician (i.e. surgeon, asst. surgeon, anesthesiologist)	50% after deductible
Outpatient Hospital – Facility Fee	Deductible then \$1,000 copay	50% after deductible
Outpatient Hospital – Physicians Fees	Deductible then \$500 copay per physician (i.e. surgeon, asst surgeon, anesthesiologist)	50% after deductible
Emergency Room	<u>True Emergency:</u> Deductible then \$500 copay <u>Non Emergency:</u> 50% after deductible	<u>True Emergency:</u> \$500 copay after network deductible <u>Non Emergency:</u> 50% after deductible

OFFICE VISIT

Office Visit for Diagnosis, Care and Consultations	<u>Primary Care:</u> \$75 copay per visit	50% after deductible
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	COPAY PLAN	
Benefit	In-Network	Out-of-Network
	<u>Specialist:</u> \$100 copay per visit	
Wellness / Preventive Care Screenings / Immunizations	Covered 100%	Not Covered
Urgent Care	\$100 copay per visit	50% after deductible
Teladoc	\$20 copay per visit	Not Available
Inpatient Facility Behavioral Health and Substance Abuse	Deductible then \$2,500 copay per admission	50% after deductible
Outpatient Behavioral Health and Substance Abuse	Office Visit: \$75 copay per visit	50% after deductible

OTHER SERVICES

Diagnostic Testing (x-ray, blood work)	<u>Lab and X-ray:</u> Deductible then \$200 copay <u>Advanced Imaging (PET, CT, MRI):</u> Deductible then \$500 copay	50% after deductible
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PRESCRIPTIONS

Retail Drug Prescriptions (Up to a 31-day supply)	Tier 1 - \$30 copay Tier 2 - \$100 copay Tier 3 - \$150 copay after deductible	50% after deductible
Mail Order Program Prescriptions (Up to a 90-day supply)	Tier 1 - \$75 copay Tier 2 - \$250 copay Tier 3 - \$375 copay after deductible	Not Applicable
Specialty Prescriptions	After deductible, \$500 copay	Must use specialty pharmacy

Copay Plan Note: Members will pay the lesser of the actual charge or the listed copay amount. Copays accrue towards the out-of-pocket maximum but NOT the deductible.

Please Note: This table is intended as a brief summary of benefits for comparison purposes only. Your Summary Plan Description provides additional details about your actual benefit and coverage level in all cases. Not all covered services, exclusions and limitations are shown here. As is customary, RBA retains the right to change or terminate these benefits as necessary.