SUMMARY OF BENEFITS 2024

PPO Option

Annual Deductible

In-Network: $500 Per Individual/$1,500 Per Family

Out-of-Network: $1,000 Per Individual/$3,000 Per Family

Out of Pocket Maximum

In-Network: $3,000 Per Individual/$9,000 Per Family (Includes Deductible)

Out-of-Network: $10,000 Per Individual /$25,000 Per Family

Plan's Portion

In-Network: 70%

Out-of-Network: 50%

	In-Network	Out-of-Network	Comments
Primary Care Physician Office Visit/ Urgent Care	$5 co-pay, then paid at 100%	$1,000 deductible and 50% of eligible expense	Primary Care Physician (PCP) means a Family Practice Physician, General Practitioner, and Internist, Nurse practitioner, Obstetrician/Gynecologist, Pediatrician or Physician's Assistant. All other providers are considered specialists.
Specialist Office Visit	$10 co-pay, then paid at 100%	$1,000 deductible and 50% of eligible expense	All other providers not listed above are considered specialists (such as a Cardiologist or Surgeon). For more information refer to the plan document.
Wellness (Routine Care)	$0 co-pay paid at 100% deductible waived	$1,000 deductible and 50% of eligible expense	Services include routine physicals and Immunizations. For more information refer to the plan document.
Diagnostic X-ray & Lab	Covered at 100% deductible waived	$1,000 deductible and 50% of eligible expense	Includes services performed on an outpatient basis in a physician office, lab facility or hospital (such as blood test and x-ray). For more information refer to plan document.
Advanced Imaging*	$500 deductible and 70% of eligible expense	$1,000 deductible and 50% of eligible expense	Includes CT scans, MRI, PET scan and nuclear medicine.
Emergency Room	$500 deductible and 70% of eligible expense	$500 deductible and 70% of eligible expense	An additional $350 co-pay applies for Non-True emergency visits.
Walgreens Take Care & CVS Minute Clinics	$0 co-pay paid at 100% deductible waived	$0 co-pay paid at 100% deductible waived	
Retail Prescription	30-day supply: $0 generic • $10 preferred brand • $20 non-preferred • $100 specialty drug 90-day supply: $0 generic • $20 preferred brand • $40 non-preferred		
Mail Order Prescription (90 Days)	$0 generic • $20 preferred brand • $40 non-preferred		
Vision	Covered at 100% deductible waived	Covered at 100% deductible waived	$300 annual limit for exams and all related hardware

Dental Benefits	
Annual Deductible	$50 per covered individual
Preventative & Diagnostic	100% no deductible
Basic Services	80% after $50 deductible
Major Services (Includes Coverage for Dental Implants)	50% after $50 deductible
Calendar Year Maximum	$2,000 per covered individual

TEAMCRAFT ROOFING

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*Teamcraft offers a weekly $5 premium credit for employees who are tobacco free. **This is a general description of benefits for more details please refer to the plan document.