SIDE-BY-SIDE COMPARISON

TEAMCRAFT ROOFING
WE SHELTER YOU

	PPO Plan		Basic Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Major Medical Deductible	$500 Individual $1,500 Family	$1,000 Individual $3,000 Family	$1,000 Individual $3,000 Family	$2,000 Individual $6,000 Family
Co-insurance	70%	50%	60%	50%
Out-of-Pocket Max (Includes Deductible)	$3,000 Individual $9,000 Family	$10,000 Individual $25,000 Family	$4,000 Individual $12,000 Family	$10,000 Individual $25,000 Family
Primary Care Physician Office Visit	$5 co-pay then 100%	50% after ded.	$10 co-pay then 100%	50% after ded.
Specialist Office Visit	$10 co-pay then 100%	50% after ded.	$15 co-pay then 100%	50% after ded.
Wellness Physical Exams (Routine Care)	$0 co-pay then 100%	50% after ded.	$0 co-pay then 100%	50% after ded.
Well Child Care (Includes Immunizations)	$0 co-pay then 100%	50% after ded.	$0 co-pay then 100%	50% after ded.
Routine Hearing Exam (1 Per Year)	100% no ded.	50% after ded.	100% no ded.	50% after ded.
Mammogram	100% no ded.	50% after ded.	100% no ded.	50% after ded.
Pap Smear	100% no ded.	50% after ded.	100% no ded.	50% after ded.
Fecal Occult Screening	100% no ded.	50% after ded.	100% no ded.	50% after ded.
Inpatient Hospital	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Outpatient Hospital*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Emergency Room**	70% after ded.	70% after ded.	60% after ded.	60% after ded.
Surgical Benefits Inpatient*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Surgical Benefits Outpatient*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Diagnostic Lab & X-Ray	100% no ded.	50% after ded.	100% no ded.	50% after ded.
CT Scans, PET Scans, MRI, & Nuclear Medicine	70% after ded.	50% after ded.	60% after ded.	50% afterded.
Prescription Drug Card	Retail Prescription (30 days): $0 generic •$10 preferred brand •$20 non-preferred •$100 specialty drug Retail Prescription (90 days): $0 generic •$20 preferred brand •$40 non-preferred Mail Order Prescription (90 days): $0 generic •$20 preferred brand •$40 non-preferred			
Mental Nervous & Substance Abuse Inpatient & Outpatient*	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Additional Medical Benefits Infusion Therapy	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Home Health Care*	100% no ded.	100% after ded.	100% no ded.	100% afterded.
Skilled Nursing Facility*	100% no ded.	100% after ded.	100% no ded.	100% afterded.
Hospice*	100% no ded.	100% after ded.	100% no ded.	100% afterded.
Birthing Center	100% no ded.	100% after ded.	100% no ded.	100% after ded.
Ambulance Service	70% after ded.	70% after in-net ded.	60% after ded.	60% after in-net ded.
Durable Medical Equipment & Supplies	70% after ded.	50% after ded.	60% after ded.	50% after ded.
Vision (Combined with Medical Plan Includes Exam & All Related Hardware)	100% no ded. Up to a $300 annual maximum			

Dental Benefits	
Annual Deductible	$50 per covered individual
Preventative & Diagnostic	100% nodeductible
Basic Restorative Services	80% after $50 deductible
Major Restorative Services (Includes Coverage for Dental Implants)	50% after $50 deductible
Calendar Year Maximum	$2,000 per covered individual

Important: *Precertification is required. You are responsible to call the number on the back of your ID card to obtain pre-certification.
**** An additional $350 co-pay applies for Non-True Emergency visits.**
This is a general description of benefits for more details please refer to the plan document