# Boutique Air, Inc.

***1-Jan-23***

| | $500 PPO | | $2000 PPO | | $3000 HSA Compatible PPO | |
|---|---|---|---|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK |
| **MEDICAL DEDUCTIBLE & MAX OF POCKET** | | | | | | |
| Deductible | $500/Individual<br>$1,000/Family | $5,000/Individual<br>$10,000/Family | $2,000/Individual<br>$6,000/Family | $8,000/Individual<br>$12,000/Family | $3,000/Individual<br>$6,000/Family | $6,000/Individual<br>$12,000/Family |
| Coinsurance *(Paid by Plan)* | 80% | 50% | 70% | 50% | 70% | 50% |
| Out-Of-Pocket Maximum<br>*(Includes Deductible, Coinsurance, and Copays)* | $3,500/Individual<br>$7,000/Family | $10,000/Individual<br>$20,000/Family | $7,350/Individual<br>$14,700/Family | $14,700/Individual<br>$29,400/Family | $6,000/Individual<br>$12,000/Family | $12,000/Individual<br>$24,000/Family |
| **WELLNESS/PREVENTIVE (Routine Care)** | | | | | | |
| Physical Examinations | Covered in full | Ded then 50% | Covered in full | Ded then 50% | Covered in full | Ded then 50% |
| Well Child Care (including immunizations) | Covered in full | Ded then 50% | Covered in full | Ded then 50% | Covered in full | Ded then 50% |
| Diagnostic X-Ray & Laboratory | Covered in full | Ded then 50% | Covered in full | Ded then 50% | Covered in full | Ded then 50% |
| **PHYSICIAN'S OFFICE VISITS** | | | | | | |
| Primary Care | $25 Copay | Ded then 50% | $50 Copay | Ded then 50% | $50 Copay | Ded then 50% |
| Specialist Office | $25 Copay | Ded then 50% | $50 Copay | Ded then 50% | $50 Copay | Ded then 50% |
| Teladoc *(General Medicine)* | $25 Copay | N/A | $40 Copay | N/A | $50 Copay | N/A |
| **DIAGNOSTIC X-RAY & LABORATORY** | | | | | | |
| Physicians Office | 100% | 100% | $50 Copay | Ded then 50% | $50 Copay | Ded then 50% |
| Specialist Office | 100% | 100% | $50 Copay | Ded then 50% | $50 Copay | Ded then 50% |
| Labs | | | | | | |
| Non-Hospital/Freestanding Facility | 100% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| Hospital (Facility Based) | Ded then 20% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| Xray | | | | | | |
| Non-Hospital/Freestanding Facility | 100% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| Hospital (Facility Based) | Ded then 20% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| Imaging Serices | | | | | | |
| Non-Hospital/Freestanding Facility | Ded then 20% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| Hospital (Facility Based) | Ded then 20% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| **HOSPITAL BENEFITS** | | | | | | |
| In-Patient | Ded then 20% | Ded then 50% | $750 Copay + 30% | $1500 Copay + 50% after deductible | Ded then 30% | Ded then 50% |
| Out-Patient Hospital | Ded then 20% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| Ambulatory Surgical Center | Ded then 20% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| Emergency Room (Waived If Admitted) | $250 Copay + 20% | Same as In-Network | $300 Copay | Same as In-Network | $300 Copay | Same as In-Network |
| Urgent Care Facility | $75 Copay | Ded then 50% | $75 Copay | Ded then 50% | Ded then 30% | Ded then 50% |
| **SURGICAL BENEFITS** | | | | | | |
| In-Patient | Ded then 20% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| Out-Patient | Ded then 20% | Ded then 50% | Ded then 30% | Ded then 50% | Ded then 30% | Ded then 50% |
| **ADDITIONAL MEDICAL BENEFITS** | | | | | | |
| Chiropractic Services | $25 Copay | Ded then 50% | N/A | N/A | N/A | N/A |
| Ambulance | Ded then 20% | Same as In-Network | Ded then 30% | Same as In-Network | Ded then 30% | Same as In-Network |
| Durable Equipment & Supplies | Ded then 20% | Ded then 50% | Ded then 30% | N/A | Ded then 30% | Ded then 50% |
| **PRESCRIPTION DRUG CARD** | | | | | | |
| RX Deductible | N/A | | $150 Individual/$300 Family | | Combined with Medical Deductible | |
| RX Out of Pocket Max | Combined with Medical Out of Pocket | | Combined with Medical Out of Pocket | | Combined with Medical Out of Pocket | |
| Retail Pharmacy Copay | $10 Generic<br>$35 Preferred<br>$60 Non-Preferred<br>Specialty: 'Follows retail pharmacy tier | | $10 Generic<br>$35 Preferred<br>$60 Non-Preferred<br>Specialty: 25% coinsurance but not more than $150 | | $10 Generic<br>$35 Preferred<br>$60 Non-Preferred<br>Specialty: 25% coinsurance but not more than $150 | |
| Mail Order Copay | 2.5 times Retail Copay for 90 day supply | | 2.5 times Retail Copay for 90 day supply | | 2.5 times Retail Copay for 90 day supply | |

***This Benefits Summary does not describe benefits and does not provide an exhaustive summary of limitations. Please refer to your Summary Plan Description for a description of Covered Services, including exclusions, limitations and services requiring prior-authorization.**