Town of Stoughton — EPO/Network Plan

*Medical Benefits for Group **BA5** Effective 07/01/2021*

	In-Network Providers
Deductible & Out-of-Pocket	
Plan Year Deductible *Single* *Family*	 $0 $0
Plan Year Out-of-Pocket Maximum *Single* *Family*	 $6,600 $13,200
Preventive Care	
Routine Physicals & Gynecological Exams	$0 copay
Other Services	
Office Visit – Primary Care	$15 copay
Office Visit – Specialist Care	$15 copay
Chiropractic Visit *(12 visits per plan year)*	$15 copay
Diagnostic Lab & X-Ray	$0 copay
CT, MRI & PET Scan	$0 copay
Outpatient Surgery	$150 copay
Inpatient Hospital	$250 copay
Behavioral Health Hospital Service	$250 copay
Behavioral Health Office Visit	$15 copay
Occupational and Physical Therapy *(60 visits combined per person, per plan year)*	$15 copay
Ambulance	$0 copay
Emergency Room *(copay waived if admitted)*	$75 copay
Routine Vision Exam	$15 copay
Fitness Reimbursement	$150 per household
Prescription Drug Benefits	**Express Scripts**
Retail Pharmacy (*up to a 30-day supply)*	$10 (Generic) / $20 (Preferred Brand) / $35 (Non-Preferred Brand)
Mail Order *(up to a 90-day supply)*	$20 (Generic) / $40 (Preferred Brand) / $70 (Non-Preferred Brand)

NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern. Please refer to your Plan Document and Amendments for complete details as well as the services that require prior authorization.