hpi | Health Plans, Inc.

Summary of Benefits

Town of Acushnet — PPO Plan

*Medical Benefits for Group **CD3** Effective 7/1/2024*

	In Network Providers	Out of Network Providers
Deductible & Out-of-Pocket		
Plan Year Deductible *Single* *Family*	 $300 $900	 $400 $800
Plan Year Out-of-Pocket Maximum *(includes Deductible, coinsurance, and copays)* *Single* *Family* *Individual within Family*	 $2,500 $5,000 $2,500	 $2,500 $5,000
Prescription Plan Year Out of Pocket Maximum *Single* *Family* *Individual within Family*	 $1,000 $2,000 $1,000	 N/A
Preventive Care		
Routine Physicals & Gynecological Exams	100%	80% after deductible
Other Services		
Office Visit – Primary Care	$20 copay	80% after deductible
Office Visit – Specialist Care	$60 copay	80% after deductible
Chiropractic Visit *(20 visits per plan year)*	$20 copay	80% after deductible
Diagnostic Lab & X-Ray	100% after deductible	80% after deductible
CT, MRI & PET Scan	$100 copay after deductible	80% after deductible
Outpatient Surgery	$250 copay after deductible	80% after deductible
Inpatient Hospital Tier 1 and Tier 2	$275 copay after deductible	80% after deductible
Inpatient Hospital Tier 3	$1,500 copay after deductible	80% after deductible
Behavioral Health Hospital Service	$275 copay per admission	80% after deductible
Behavioral Health Office Visit	$20 copay	80% after deductible
Occupational and Physical Therapy (*30 visits each per plan year)*	$20 copay	80% after deductible
Speech Therapy	$20 copay	80% after deductible
Ambulance	100% after deductible	
Emergency Room *(copay waived if admitted)*	$100 copay after deductible	
Urgent Care	$20 copay	80% after deductible
Prescription Drug Benefits	**Express Scripts**	
Retail Pharmacy (*up to a 30-day supply)*	$10 (Generic) / $30 (Preferred Brand) / $65 (Non-Preferred Brand)	
Retail Pharmacy (*up to a 90-day supply)*	$30 (Generic) / $90 (Preferred Brand) / $195 (Non-Preferred Brand)	
Mail Order *(up to a 90-day supply)*	$25 (Generic) / $75 (Preferred Brand) / $165 (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.