



**Town of Grafton — ChoiceNet PPO Plan**

Medical Benefits for Group CD2 Effective 7/1/2023

	In- Network Providers	Out of Network Providers
<b>Deductible &amp; Out-of-Pocket</b>		
Plan Year Deductible		
<i>Single</i>	\$500	\$500
<i>Family</i>	\$1,000	\$1,000
<i>Individual within Family</i>	\$500	\$500
Plan Year Out-of-Pocket Maximum ( <i>includes Deductible, coinsurance, and copays</i> )		
<i>Single</i>	\$5,000	\$5,000
<i>Family</i>	\$10,000	\$10,000
<i>Individual within Family</i>	\$5,000	\$5,000
<b>Preventive Care</b>		
Routine Physicals & Gynecological Exams	100%	80% after deductible
<b>Other Services</b>		
Office Visit – Primary Care		
<i>Tier 1</i>	\$10 copay	80% after deductible
<i>Tier 2</i>	\$20 copay	
<i>Tier 3</i>	\$40 copay	
Office Visit – Specialist Care		
<i>Tier 1</i>	\$30 copay	80% after deductible
<i>Tier 2</i>	\$60 copay	
<i>Tier 3</i>	\$75 copay	
Chiropractic Visit ( <i>20 visits per plan year</i> )	\$20 copay	80% after deductible
Diagnostic Lab & X-Ray	100% after deductible	80% after deductible
CT, MRI & PET Scan	\$100 after deductible	80% after deductible
Outpatient Surgery	\$250 after deductible	80% after deductible
Inpatient Hospital		
<i>Tier 1</i>	\$275 copay after deductible	80% after deductible
<i>Tier 2</i>	\$500 copay after deductible	
<i>Tier 3</i>	\$1,000 copay after deductible	
Behavioral Health Hospital Service	\$200 copay	80% after deductible
Behavioral Health Office Visit	\$10 copay	80% after deductible
Occupational and Physical Therapy ( <i>30 visits each per plan year</i> )	\$20 copay	80% after deductible
Speech Therapy	\$20 copay	80% after deductible
Ambulance	100%	
Emergency Room ( <i>copay waived if admitted</i> )	\$100 copay	
Urgent Care- Urgent Care Center & Hospital Urgent Care Center	\$20 copay	80% after deductible
Urgent Care – Convenience Care Clinic		
<i>Tier 1</i>	\$10 copay	80% after deductible
<i>Tier 2</i>	\$20 copay	
<i>Tier 3</i>	\$40 copay	
<b>Prescription Drug Benefits</b>		
<b>Express Scripts</b>		
Retail Pharmacy ( <i>up to a 30-day supply</i> )	\$10 (Generic) / \$30 (Preferred Brand) / \$65 (Non-Preferred Brand)	
Mail Order ( <i>up to a 90-day supply</i> )	\$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.