Town of Medway — ChoiceNet Network Plan

Medical Benefits for Group BP5 Effective 7/1/2023

	In-Network Providers
Deductible & Out-of-Pocket	
Annual Plan Year Deductible Single Family	\$300 \$900
Annual Out-of-Pocket Maximum (includes Deductible and copays) Single Family Individual within Family	\$3,000 \$6,000 \$3,000
Preventive Care	
Routine Physicals & Gynecological Exams	100%
Other Services	
Office Visit – Primary Care	\$30 copay
Office Visit – Specialist Care	\$45 copay
Chiropractic Visit (20 visits per plan year)	\$30 copay
Diagnostic Lab & X-Ray	100%
CT, MRI & PET Scan	\$100 copay after deductible
Outpatient Surgery	\$250 copay after deductible
Inpatient Hospital Tier 1 and Tier 2	\$300 copay after deductible
Inpatient Hospital Tier 3	\$1,500 copay after deductible
Behavioral Health Hospital Service	\$300 copay after deductible
Behavioral Health Office Visit	\$30 copay
Occupational and Physical Therapy (30 visits each per plan year)	\$45 copay
Speech Therapy	\$45 copay
Ambulance	100%
Emergency Room (copay waived if admitted)	\$100 copay after deductible
Urgent Care – Convenience Care	\$30 copay
Urgent Care Center	\$45 copay
Urgent Care – Hospital Based	\$45 copay
Prescription Drug Benefits	Express Scripts
Retail Pharmacy (up to a 30-day supply)	\$10 (Generic) / \$30 (Preferred Brand) / \$65 (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.