Town of Stoughton — EPO/Network Plan

*Medical Benefits for Group **BA5** Effective 07/01/2024*

Covered Services	In-Network Providers
Deductible & Out-of-Pocket	
Plan Year Deductible *Single* *Family* *Individual Within Family*	 $250 $500 $250
Plan Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays) *Single* *Family*	 $6,600 $13,200
Preventive Care	
Routine Physicals & Gynecological Exams	$0 copay
Other Services	
Office Visit – Primary Care	$20 copay
Office Visit – Specialist Care	$30 copay
Chiropractic Visit *(12 visits per plan year)*	$20 copay
Diagnostic Lab & X-Ray	100% after deductible
CT, MRI & PET Scan	$50 copay after deductible
Outpatient Surgery	$150 copay after deductible
Inpatient Hospital	$250 copay after deductible
Behavioral Health Hospital Service	$250 copay
Behavioral Health Office Visit	$20 copay
Occupational and Physical Therapy *(60 visits combined per plan year)*	$20 copay
Ambulance	100% after deductible
Emergency Room *(copay waived if admitted)*	$100 copay after deductible
Routine Vision Exam	100%
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.