hpi | Health Plans, Inc.

Summary of Benefits

Town of Medway – ChoiceNet PPO Plan

*Medical Benefits for Group **BP5** Effective 7/1/2024*

	In-Network	Out-of-Network
Deductible & Out-of-Pocket		
Annual Plan Year Deductible *Single* *Family*	 $300 $900	 $400 $800
Annual Out-of-Pocket Maximum *(includes Deductible, coinsurance, and copays)* *Single* *Family* *Individual within Family*	 $3,000 $6,000 $3,000	 $3,000 $6,000
Preventive Care		
Routine Physicals & Gynecological Exams	100%	80% allowed amount after deductible
Other Services		
Office Visit – Primary Care	$30 copay	80% allowed amount after deductible
Office Visit – Specialist Care	$45 copay	80% allowed amount after deductible
Chiropractic Visit *(20 visits per plan year)*	$30 copay	80% allowed amount after deductible
Diagnostic Lab & X-Ray	100%	80% allowed amount after deductible
CT, MRI & PET Scan	$100 copay after deductible	80% allowed amount after deductible
Outpatient Surgery	$250 copay after deductible	80% allowed amount after deductible
Inpatient Hospital – Tier 1 and Tier 2	$300 copay after deductible	80% allowed amount after deductible
Inpatient Hospital – Tier 3	$1,500 copay after deductible	80% allowed amount after deductible
Behavioral Health Hospital Service	$300 copay after deductible	80% allowed amount after deductible
Behavioral Health Office Visit	$30 copay	80% allowed amount after deductible
Occupational and Physical Therapy (*30 visits per plan year)*	$45 copay	80% allowed amount after deductible
Speech Therapy	$45 copay	80% allowed amount after deductible
Ambulance	100%	100% allowed amount after In-Network Deductible
Emergency Room *(copay waived if admitted)*	$100 copay after deductible	$100 copay after In-Network deductible
Urgent Care – Convenience Care	$30 copay	80% allowed amount after deductible
Urgent Care Center	$45 copay	80% allowed amount after deductible
Urgent Care – Hospital Based	$45 copay	80% allowed amount after deductible
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.