IncredibleBank

Benefit Summary

Effective Date: January 1, 2024

	PPO Plan		HDHP #1		HDHP #2	
General Plan Information	***In-Network***	***Out-of-Network***	***In-Network***	***Out-of-Network***	***In-Network***	***Out-of-Network***
Deductible	$0 Single $0 Employee + Spouse, Employee + Child(ren) & Family	$1,000 Single $2,000 Employee + Spouse, Employee + Child(ren) & Family	$1,600 Single $3,200 Employee + Spouse, Employee + Child(ren) & Family	$3,200 Single $6,400 Employee + Spouse, Employee + Child(ren) & Family	$3,200 Single $6,400 Employee + Spouse, Employee + Child(ren) & Family	$6,400 Single $12,800 Employee + Spouse, Employee + Child(ren) & Family
Embedded Deductible - the maximum amount that any one individual can satisfy toward the annual family deductible	N/A	$1,000	N/A	N/A	$3,200	$6,400
Coinsurance	80%	60%	80%	60%	80%	60%
Out-of-Pocket Maximum (Including Employees Deductible & co-insurance)	$3,500 Single $7,000 Employee + Spouse, Employee + Child(ren) & Family	$7,000 Single $14,000 Employee + Spouse, Employee + Child(ren) & Family	$3,200 Single $6,400 Employee + Spouse, Employee + Child(ren) & Family	$6,400 Single $12,800 Employee + Spouse, Employee + Child(ren) & Family	$6,400 Single $12,800 Employee + Spouse, Employee + Child(ren) & Family	$12,800 Single $25,600 Employee + Spouse, Employee + Child(ren) & Family
Embedded Out-of-Pocket Maximum - the maximum amount that any one individual can satisfy toward the annual family out-of-pocket maximum	$3,500	$7,000	N/A	N/A	$6,400	$12,800
Dependent Eligibility	26		26		26	
Physician Services						
Preventive Care - Annual Physical, well-child care, lab tests, immunizations, flu shots	100%	Not Covered	100%	Not Covered	100%	Not Covered
Mammograms, Paps, PSA & Colonoscopy	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Office Visits	$25 Copay	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Specialist	$50 Copay	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Teladoc (general medicine, behavioral health, dermatology)	$0 Copay	N/A	80% after deductible	N/A	80% after deductible	N/A
Urgent Care	$100 Copay	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Diagnostic X-Ray & Lab	$25 Copay, copayment may differ depending on place of service and date incurred	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Chiropractic Care	$10 Copay	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment (DME)	80%	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment (DME) Exams/Tests	Office Visit or Specialist Copay ($25/$50)	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Imaging (MRI, CT/PET Scans)	80% coinsurance, unless part of UC ($100 Copay) or ER ($300 Copay) visit	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Therapy (Occupational & Speech)	In office is $25 Copay Out-patient is 80% coinsurance	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Walk-in	Office Visit, Specialist, or Urgent Care Copay depending on the location and service ($25/$50/$100)	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospital Services						
Inpatient	80%	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient	80%	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Care						
Emergency Room	$300 Copay	$300 Copay	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Prescription Drugs						
Preventive	Generic, Brand, Non- Preferred Brand - Paid at 100%		Generic, Brand, Non- Preferred Brand - Paid at 100%		Generic, Brand, Non- Preferred Brand - Paid at 100%	
Generic/Preferred/Non-Preferred/Specialty	$10/$30/$50/20% coinsurance up to $200		80% after deductible		80% after deductible	

Medical Deductions

Coverage Type	Bi-Weekly Payroll Deduction	Bi-Weekly Payroll Deduction	Bi-Weekly Payroll Deduction
Single	$57.94	$55.76	$40.03
Employee + Spouse	$139.05	$133.82	$92.46
Employee + Child(ren)	$115.87	$115.52	$77.05
Family	$196.98	$189.58	$130.99

Dental Deductions

Coverage Type	Bi-Weekly Payroll Deduction
Single	$3.32
Employee + Spouse	$6.65
Employee + Child(ren)	$8.73
Family	$12.48

Vision Deductions

Coverage Type	Bi-Weekly Payroll Deduction
Single	$1.08
Employee + Spouse	$2.15
Employee + Child(ren)	$1.94
Family	$3.16