MEDICAL	Care Plus (EMI)	Signature Plan
Deductible	$500 / $1,500	No change
Out of Pocket Maximum	$7,500 / $15,000	No change
Routine / Preventive Services	Covered 100%	No change
FSA- Eligiblity?	Yes	No change
Out of Network Coverage	50% coinsurance	Urgent and Emergency care only. Same benefits as below.
Standard Coinsurance	0.2	No change
Primary Care Office Visits	$15 copay	No change
Specialist Office Visits	$30 copay	No change
Behavioral Health Office Visists	$30 copay	$10 copay
Physician Services (Inpatient & Outpatient)	20% after deductible	No change
Radiology and Lab (in-office & outpatient)	$0 after deductible	No change
Radiology & Lab (inpatient)	20% after deductible	No change
Outpatient Radiology	$0 after deductible	$0 deductible waived at Steinberg Diagnostic Medical Imaging (SDMI), otherwise, $0 after deductible.
Outpatient Lab	$0 after deductible	$0 deductible waived at Quest Diagnostics, otherwise, $0 after deductible.
Routine Prenatal & Delivery (Dependent maternity included)	$10 office visit; 20% all other services	Routine prenatal: covered 100% deductible waived. Delivery: 20% after deductible
Rehabilitation Therapy (Outpatient cardiac or pulmonary)	$30 copay	No change
Chiropractic Therapy (20 visits per year)	$30 copay	No change
Acupuncture Services (20 visits per Year)	$30 copay	No change
Emergency Room (ER)	$300 copay after deductible	Co-pay For First Visit In The Plan Year: $300 after deductible; Co-pay For All Subsequent Visits In The Plan Year $750 after deductible
Urgent Care Clinic	$30 copay	No change

PHARMACY	Care Plus (EMI)	Signature Plan
Non-Specialty Generic (Tier 1)	$15 copay (≤30 days) $40 copay (≤90 days)	$15 (1–34 days) $40 (35–90 days)
Non-Specialty Preferred (Tier 2)	25% up to $100 (≤30 days) 25% up to $300 (≤90 days)	25% up to $100 (1–34 days) 25% up to $300 (35–90 days)
Non-Specialty Non-Preferred (Tier 3)	0.4	0.4
Specialty Generic (Tier 1) & Preferred (Tier 2)	25% up to $1,500	25% up to $500

DENTAL	EMI Dental	Dental PPO
Deductible (Individual/Family)	$0	No change
Annual Maximum (per person)	1500	No change
Preventive Care		
Oral Exams	100%	No change
Cleanings (2 per year)	100%	No change
Routine X-Rays	100%	No change
Basic Services		
Periodontal Services	80%	No change
Endodontics (Molar / Other)	80%	No change
Oral Surgery	80%	No change
Fillings	80%	No change
Sealants	80%	No change
Major Services		
Crowns / Inlays / Onlays	60%	No change
Bridges	60%	No change
Dentures (Full/Partial) / Prosthodontics	60%	No change
TMJ Appliance	20%	60% up to $500 lifetime
Orthodontics	50% (age 7–18)	100% up to $1,000 (age ≤18)
Out-of-Network Coverage	Yes, but at reduced rates and subject to Maximum Allowable Charge.	Yes, but at reduced rates
Referrals Required for Specialists	No	No change
Must Select a General Dentist	No	No change

VISION	EMI / VSP	VSP Choice – Standard Vision
WellVision Exam	$10 copay	$20 copay, up to $39
Exam Frequency	Once per plan year	No change
Frames Frequency	Every 12 months	Every other plan year
Frames Allowance	$130 allowance at VSP doctor OR $70 at Costco/Sam's/Walmart	No change
Lenses	$10 copay (Single, Bifocal, Trifocal, Lenticular)	$0 copay
Progressive	$0 copay	No change
Premium Progressive	$95–$105 copay	No change
Custom Progressive	$150–$175 copay	No change
Additional Lens Enhancements	Up to 25% discount	No change
Contact Lens Exam	Included in allowance	Up to $60 copay
Contact Lens Allowance	$130 allowance (in lieu of frames & lenses)	$120 allowance
Refractive / LASIK Surgery	Up to $500 in savings	Avg. 15–20% off (5% off promos)