

MEDICAL AND PHARMACY BENEFIT INFORMATION

	Plan 3 - PPO w/ Rx Plan B Member Responsibility		Plan 5 - PPO w/ Rx Plan B Member Responsibility		Plan 8 - PPO w/ Rx Plan C Member Responsibility		Plan 1 - HMO w/ Rx Plan 1 Member Responsibility	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Plan Year October 1 - September 30								
Individual Deductible (plan year)	\$100	\$100	\$200	\$200	\$1,000	\$1,000	\$0.00	\$300
Family Deductible (plan year)	\$300	\$300	\$600	\$600	\$3,000	\$3,000	\$0.00	\$900
Individual Out-of-Pocket Maximum (plan year)	\$500	\$1,500	\$1,000	\$2,000	\$2,000	\$4,000	\$1,000	\$2,000
Family Out-of-Pocket Maximum (plan year)	N/A	N/A	N/A	N/A	N/A	N/A	\$2,000	\$4,000
Lifetime Maximum Benefit	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Member Coinsurance	10%	30%	20%	40%	20%	40%	0%	50%

Physician & Professional Services

Office, Home or Hospital visit	\$10	30%	\$20	40%	20%	40%	\$10	\$50
Outpatient Rehabilitation (physical, occupational and speech therapy - 30/60 days per plan year)	\$10	30%	\$20	40%	20%	40%	\$10 (30 days per plan year)	50% (30 days per plan year)
Anesthesiologist	10%	30%	20%	40%	20%	40%	covered in full	50%

Emergency & Urgent Care

Emergency Room (waived if admitted)	\$100 per visit then 10%		\$100 per visit then 20%		\$100 copayment per visit then 20%		\$100	\$100, then 50%*
RN Advice for minor illnesses	eDoc		eDoc		eDoc		Yes	Yes
Urgent Care Visits	\$10		\$20		20%		\$25	25*
Ambulance Transportation (\$5,000 annual maximum)	10% (ground or air)		20% (ground or air)		20% (ground or air)		\$100 (ground or air)	\$100* (ground or air)

Hospital Benefit

Inpatient Hospital - authorization required	10%	30%	20%	40%	20%	40%	\$100 per day	50%
Service Authorization Penalty Inpatient & Residential	50% up to \$2500	50% up to \$2500	50% up to \$2500	50% up to \$2500	50% up to \$2500	50% up to \$2500	N/A	50%, \$2500 max/occurrence
Inpatient Days Covered	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited
Inpatient Rehabilitative Hospital Care (30/60 days per plan year)	10%	30%	20%	40%	20%	40%	\$100 per day 30 days per year	50% 30 days per year
Pre-admission Testing	10%	30%	20%	40%	20%	40%	covered in full	50%

Outpatient Hospital Services

Outpatient Surgery	10%	30%	20%	40%	20%	40%	covered in full	50%
Diagnostic X-rays & Laboratory Tests	10%	30%	20%	40%	20%	40%	covered in full	50%
Chemotherapy	10%	30%	20%	40%	20%	40%	covered in full	50%
Radium, Radioisotopic, X-Ray Therapy & Kidney Dialysis	10%	30%	20%	40%	20%	40%	covered in full	50%
Imaging Procedures	10%	30%	20%	40%	20%	40%	covered in full	50%

Skilled Nursing Facility

Skilled Nursing Facility (60 per plan year)	10%	30%	20%	40%	20%	40%	\$100 per day	50%
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Other Care, Services & Treatments

Allergy Testing	10%	30%	20%	40%	20%	40%	covered in full	50%
Allergy Injections	10%	30%	20%	40%	20%	40%	covered in full	50%
Cochlear Implants service authorization required	10%	30%	20%	40%	20%	40%	covered in full	50%
Cosmetic & Reconstructive Surgery medically necessary - authorization required	10%	30%	20%	40%	20%	40%	covered as any other surgery	50%
Infusion Therapy - authorization required	10%	30%	20%	40%	20%	40%	covered in full	50%
Injectible Medication (administered in provider's office)	10%	30%	20%	40%	20%	40%	covered in full	50%
Maxillofacial Prosthetic Services (medically necessary)	10%	30%	20%	40%	20%	40%	covered in full	50%
Medical Equipment (Durable), Supplies and Appliances	10%	30%	20%	40%	20%	40%	covered in full	50%
Orthotic & Prosthetic Appliances (medically necessary)	10%	30%	20%	40%	20%	40%	covered in full see limitations	50% see limitations
Podiatry Services (medically necessary)	10%	30%	20%	40%	20%	40%	\$10	50%
Temporomandibular Joint Syndrome (\$3000 lifetime maximum)	10%	30%	20%	40%	20%	40%	covered in full	50%
Therapeutic Injections	10%	30%	20%	40%	20%	40%	covered in full	50%
Transplants (\$250,000 lifetime maximum - authorization required)	\$0	30%	\$0	40%	\$0	40%	covered as any other surgery	N/A

Chemical Dependency

Deductible per Confinement	10%	30%	20%	40%	20%	40%	Prior authorization is required. Call (800) 878-4445. Individual & family annual deductibles apply. Call insurance carrier for more information on coverage details.
Deductible per Day	10%	30%	20%	40%	20%	40%	
Detoxification	10%	30%	20%	40%	20%	40%	
Inpatient Treatment	10%	30%	20%	40%	20%	40%	
Outpatient Office Visits	\$10	30%	\$20	40%	20%	40%	

Mental Illness

Deductible per Confinement	10%	30%	20%	40%	20%	40%	Prior authorization is required. Call (800) 878-4445. Individual & family annual deductibles apply. Call insurance carrier for more information on coverage details.
Deductible per Day	10%	30%	20%	40%	20%	40%	
Inpatient Treatment	10%	30%	20%	40%	20%	40%	
Outpatient Office Visits	\$10	30%	\$20	40%	20%	40%	
Group Therapy	\$10	30%	\$20	40%	20%	40%	
Mental Health Residential Care (45 days per plan year)	10%	30%	20%	40%	20%	40%	

N/A = No benefit

*deductible does not apply

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Pharmacy

	Plan 3 - PPO w/ Rx Plan B	Plan 5 - PPO w/ Rx Plan B	Plan 8 - PPO w/ Rx Plan C	Plan 1 - HMO w/ Rx Plan 1
Deductible	None	None	None	None
Annual Copay/Out of Pocket Maximum	\$1,000	\$1,000	\$1,000	\$1,000
Retail (31 day supply)				
Generic	\$5	\$5	50%	\$5
Preferred	\$25	\$25	50%	\$15
Non-Preferred	50%, \$50 max	50%, \$50 max	50%	N/A
Mail (90 day supply)				
Generic	\$10	\$10	50%	\$10
Preferred	\$50	\$50	50%	\$30
Non-Preferred	50%, \$100 max	50%, \$100 max	50%	N/A

DENTAL INFORMATION

	Insurance Pays Plan 1 - ODS	Insurance Pays Plan 3 - ODS	Insurance Pays Plan 5 - ODS
Deductible	None	None	\$50
Annual Maximum	\$2,200	\$1,500	\$1,500
Preventative Care	coverage begins at 70% increase of 10% yearly thereafter	coverage begins at 70% increase of 10% yearly thereafter	100%
Restorative Services	coverage begins at 70% increase of 10% yearly thereafter	coverage begins at 70% increase of 10% yearly thereafter	80%
Major Services	coverage begins at 70% increase of 10% yearly thereafter	coverage begins at 70% increase of 10% yearly thereafter	50%
Prosthodontics	coverage begins at 70% increase of 10% yearly thereafter	50%	50%
Orthodontia	80% to \$1500 lifetime max	80% to \$1500 lifetime max	80% to \$1500 lifetime max

VISION INFORMATION

	Insurance Pays Plan 4 - ODS
Plan Maximum	\$600
Routine Eye Exam	100%
Exam Frequency	every 12 months
Lenses (every 12 months)	Either one pair of lenses or contacts
Single Vision	100%
Bifocal	100%
Lenticular	100%
Trifocal	100%
Contact Lenses	100%
Frames child: every 12 months adult: every 24 months	100%

This summary is not a guarantee of benefits. Additional details, requirements, limitations and exclusions may apply. Please contact your insurance carrier for any individual medical related benefit questions.