Medical Plan Schedule of Benefits
PPO $3000 Deductible

The following is a summary of the benefits, subject to co-payments, deductibles, percentages and limitations, provided to you and any covered dependents. *Please note the Calendar Year Deductibles are always applicable, unless the schedule states they are waived.* PLEASE REFER TO THE LIMITATIONS AND EXCLUSIONS FOR ADDITIONAL EXPLANATIONS.		
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MAXIMUM PLAN BENEFIT	$2,000,000	
CALENDAR YEAR DEDUCTIBLE		
Individual	$3,000	$6,000
Per Family Unit	$6,000	$12,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$3,000	$6,000
Per Family Unit	$6,000	$12,000
	Network Deductible & Out-of-Pocket ***will only*** apply toward Network Deductible & Out-of-Pocket Maximum	Out-of-Network Deductible & Out-of-Pocket ***will also*** apply toward Network Deductible & Out-of-Pocket Maximum
COVERED CHARGES		
Medical/Surgical Expenses		
Services performed during the physician office visit/consultation including lab, x-ray (does not include *Certain Diagnostic Procedures & surgical services*)	$25 Copay then 100%, Deductible Waived	60% of Allowable Amount
Lab & x-ray in other outpatient facilities (excluding *Certain Diagnostic Procedures)*	100% of Allowable Amount, Deductible waived	60% of Allowable Amount
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan, Ultrasound, MRI, Myelogram, PET Scan, surgical procedures and all other services & supplies.	80% of Allowable Amount	60% of Allowable Amount
In Vitro Fertilization Services	Not Covered	
Urgent Care Services Center visit, including Lab & X-ray (does not include *Certain Diagnostic Procedures & Surgical Services)*	$50 Copay then 100%, Deductible Waived	60% of Allowable Amount
Ground & Air Ambulance Services	80% of Allowable Amount	
Inpatient Hospital Expenses		
All services must be preauthorized All usual Hospital services & supplies, including semiprivate room, intensive care & coronary care units	80% of Allowable Amount	60% of Allowable Amount after per-admission deductible
Penalty for Failure to preauthorize services	None	$250

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Emergency Room /Treatment Room (within 48 hours of accidental injury)	$100 Copay, then 80% of Allowable Amount, Deductible Waived (Copayment waived if admitted, Inpatient Hospital expenses will apply)	
ER Physicians	80% of Allowable Amount	
Non-emergency care (after 48 hours)	$100 Copay, then 80% of Allowable Amount, Deductible Waived (Copayment waived if admitted, Inpatient Hospital expenses will apply)	$100 Copay, then 60% of Allowable Amount (Copayment waived if admitted, Inpatient Hospital expenses will apply)
ER Physicians	80% of Allowable Amount	60% of Allowable Amount
Preventative Care Routine physical exams, well-baby exams, immunizations for participants 6 years & over, vision & hearing exams	$25 Copay, then 100% deductible waived	60% of Allowable Amount
Immunizations for dependent children through the date of the child's 6th birthday	100% of Allowable Amount, Deductible Waived	
Speech Therapy Services to restore loss of or correct an impaired speech or hearing function	Covered the same as any other sickness	
Hearing Aids	80% of Allowable Amount	60% of Allowable Amount
Hearing Aid Maximum	$1,000 each 36 month period	
Physical Medicine Services Includes but is not limited to physical, occupational & manipulative therapy	80% of Allowable Amount	60% of Allowable Amount
Calendar Year Maximum	$1,500	
Extended Care Services *All services must be preauthorized*	100% of Allowable Amount, Deductible Waived	60% of Allowable Amount
Home Health Care	$10,000 Calendar Year Maximum	
Skilled Nursing Facility	$10,000 Calendar Year Maximum	
Hospice Services	$20,000 Lifetime Maximum	
Serious Mental Illness, Mental Health Care, Treatment of Chemical Dependency *All services must be preauthorized* **Inpatient Services** (Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center)		
Hospital Services (facility)	80% of Allowable Amount, Deductible Waived	60% of Allowable Amount, Deductible Waived
Physician Services	80% of Allowable Amount	60% of Allowable Amount

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Outpatient Services		
All services must be preauthorized Services performed during Physician office visit (does not Include psychological testing)	$25 Copay, then 100%, Deductible Waived	60% of Allowable Amount
Organ and Transplant Services	Covered as any other illness- Refer to benefit booklet for details	
Calendar Year Maximum	$15,000 max benefit for donor search & acceptability testing of potential live donors	
Three-month deductible carryover applies. Credit for Deductible Out-of-Pocket Maximum from prior carrier applied on initial group enrollment only.		

PRESCRIPTION DRUG BENEFIT SCHEDULE

	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy 30-Day Supply		
Generic	$15	60% of Allowable Amount minus Copayment
Preferred Brand	$30	60% of Allowable Amount minus Copayment
Non-Preferred Brand	$50	60% of Allowable Amount minus Copayment
Mail Order Pharmacy 90-Day Supply		
Generic	$15 Copayment	
Preferred Brand	$30 Copayment	
Non-Preferred Brand	$50 Copayment	

Vaccinations obtained through pharmacies $15 copayment, deductibles do not apply.

OTC Omeprazole 20 mg covered under the plan. All other OTC meds are not covered.

Diabetic supplies are covered under the plan.

Medical Plan Schedule of Benefits
PPO $5000 Deductible

The following is a summary of the benefits, subject to co-payments, deductibles, percentages and limitations, provided to you and any covered dependents. *Please note the Calendar Year Deductibles are always applicable, unless the schedule states they are waived.* PLEASE REFER TO THE LIMITATIONS AND EXCLUSIONS FOR ADDITIONAL EXPLANATIONS.		
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MAXIMUM PLAN BENEFIT	$2,000,000	
CALENDAR YEAR DEDUCTIBLE		
Individual	$5,000	$10,000
Per Family Unit	$10,000	$20,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$3,000	$6,000
Per Family Unit	$6,000	$12,000
	Network Deductible & Out-of-Pocket ***will only*** apply toward Network Deductible & Out-of-Pocket Maximum	Out-of-Network Deductible & Out-of-Pocket ***will also*** apply toward Network Deductible & Out-of-Pocket Maximum
COVERED CHARGES		
Medical/Surgical Expenses		
Services performed during the physician office visit/consultation including lab, x-ray (does not include *Certain Diagnostic Procedures & surgical services*)	$25 Copay then 100%, Deductible Waived	60% of Allowable Amount
Lab & x-ray in other outpatient facilities (excluding *Certain Diagnostic Procedures)*	100% of Allowable Amount, Deductible waived	60% of Allowable Amount
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan, Ultrasound, MRI, Myelogram, PET Scan, surgical procedures and all other services & supplies.	80% of Allowable Amount	60% of Allowable Amount
In Vitro Fertilization Services	Not Covered	
Urgent Care Services Center visit, including Lab & X-ray (does not include *Certain Diagnostic Procedures & Surgical Services)*	$50 Copay then 100%, Deductible Waived	60% of Allowable Amount
Ground & Air Ambulance Services	80% of Allowable Amount	
Inpatient Hospital Expenses		
All services must be preauthorized All usual Hospital services & supplies, including semiprivate room, intensive care & coronary care units	80% of Allowable Amount	60% of Allowable Amount after per-admission deductible
Penalty for Failure to preauthorize services	None	$250

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Emergency Room /Treatment Room (within 48 hours of accidental injury)	$100 Copay, then 80% of Allowable Amount, Deductible Waived (Copayment waived if admitted, Inpatient Hospital expenses will apply)	
ER Physicians	80% of Allowable Amount	
Non-emergency care (after 48 hours)	$100 Copay, then 80% of Allowable Amount, Deductible Waived (Copayment waived if admitted, Inpatient Hospital expenses will apply)	$100 Copay, then 60% of Allowable Amount (Copayment waived if admitted, Inpatient Hospital expenses will apply)
ER Physicians	80% of Allowable Amount	60% of Allowable Amount
Preventative Care Routine physical exams, well-baby exams, immunizations for participants 6 years & over, vision & hearing exams	$25 Copay, then 100% deductible waived	60% of Allowable Amount
Immunizations for dependent children through the date of the child's 6th birthday	100% of Allowable Amount, Deductible Waived	
Speech Therapy Services to restore loss of or correct an impaired speech or hearing function	Covered the same as any other sickness	
Hearing Aids	80% of Allowable Amount	60% of Allowable Amount
Hearing Aid Maximum	$1,000 each 36 month period	
Physical Medicine Services Includes but is not limited to physical, occupational & manipulative therapy	80% of Allowable Amount	60% of Allowable Amount
Calendar Year Maximum	$1,500	
Extended Care Services *All services must be preauthorized*	100% of Allowable Amount, Deductible Waived	60% of Allowable Amount
Home Health Care	$10,000 Calendar Year Maximum	
Skilled Nursing Facility	$10,000 Calendar Year Maximum	
Hospice Services	$20,000 Lifetime Maximum	
Serious Mental Illness, Mental Health Care, Treatment of Chemical Dependency *All services must be preauthorized* **Inpatient Services** (Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center)		
Hospital Services (facility)	80% of Allowable Amount, Deductible Waived	60% of Allowable Amount, Deductible Waived
Physician Services	80% of Allowable Amount	60% of Allowable Amount

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Outpatient Services		
All services must be preauthorized Services performed during Physician office visit (does not Include psychological testing)	$25 Copay, then 100%, Deductible Waived	60% of Allowable Amount
Organ and Transplant Services	Covered as any other illness- Refer to benefit booklet for details	
Calendar Year Maximum	$15,000 max benefit for donor search & acceptability testing of potential live donors	
Three-month deductible carryover applies. Credit for Deductible Out-of-Pocket Maximum from prior carrier applied on initial group enrollment only.		

PRESCRIPTION DRUG BENEFIT SCHEDULE

	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy 30-Day Supply		
Generic	$15	60% of Allowable Amount minus Copayment
Preferred Brand	$30	60% of Allowable Amount minus Copayment
Non-Preferred Brand	$50	60% of Allowable Amount minus Copayment
Mail Order Pharmacy 90-Day Supply		
Generic	$15 Copayment	
Preferred Brand	$30 Copayment	
Non-Preferred Brand	$50 Copayment	

Vaccinations obtained through pharmacies $15 copayment, deductibles do not apply.

OTC Omeprazole 20 mg covered under the plan. All other OTC meds are not covered.

Diabetic supplies are covered under the plan.

Medical Plan Schedule of Benefits
HSA $5000 Deductible

The following is a summary of the benefits, subject to co-payments, deductibles, percentages and limitations, provided to you and any covered dependents. *Please note the Calendar Year Deductibles are always applicable, unless the schedule states they are waived.* PLEASE REFER TO THE LIMITATIONS AND EXCLUSIONS FOR ADDITIONAL EXPLANATIONS.		
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MAXIMUM PLAN BENEFIT	$5,000,000	
CALENDAR YEAR DEDUCTIBLE		
Individual	$5,000	$10,000
Per Family Unit	$10,000	$20,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$5,000	$20,000
Per Family Unit	$10,000	$40,000
	Network Deductible & Out-of-Pocket ***will only*** apply toward Network Deductible & Out-of-Pocket Maximum	Out-of-Network Deductible & Out-of-Pocket ***will also*** apply toward Network Deductible & Out-of-Pocket Maximum
COVERED CHARGES		
Medical/Surgical Expenses		
Services performed during the physician office visit/consultation including lab, x-ray (does not include *Certain Diagnostic Procedures & surgical services*)	100%, Deductible Waived	70% of Allowable Amount
Lab & x-ray in other outpatient facilities (excluding *Certain Diagnostic Procedures)*	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan, Ultrasound, MRI, Myelogram, PET Scan, surgical procedures and all other services & supplies.	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
In Vitro Fertilization Services	Not Covered	
Urgent Care Services Center visit, including Lab & X-ray (does not include *Certain Diagnostic Procedures & Surgical Services)*	100 of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
Ground & Air Ambulance Services	100% of Allowable Amount after Deductible	
Inpatient Hospital Expenses		
All services must be preauthorized All usual Hospital services & supplies, including semiprivate room, intensive care & coronary care units	100% of Allowable Amount	70% of Allowable Amount after per-admission deductible
Penalty for Failure to preauthorize services	None	$250

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Emergency Room /Treatment Room (within 48 hours of accidental injury)	100% of Allowable Amount after Deductible	
ER Physicians	100% of Allowable Amount after Deductible	
Non-emergency care (after 48 hours)	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
ER Physicians	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
Preventative Care Routine physical exams, well-baby exams, immunizations for participants 6 years & over, vision & hearing exams	100% of Allowable Amount	70% of Allowable Amount
Immunizations for dependent children through the date of the child's 6th birthday	100% of Allowable Amount, Deductible Waived	
Speech Therapy Services to restore loss of or correct an impaired speech or hearing function	Covered the same as any other sickness	
Hearing Aids	100% of Allowable Amount	70% of Allowable Amount
Hearing Aid Maximum	$1,000 each 36 month period	
Physical Medicine Services Includes but is not limited to physical, occupational & manipulative therapy	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
Calendar Year Maximum	$1,000 each 36 month period	
Extended Care Services *All services must be preauthorized*	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
Home Health Care	$10,000 Calendar Year Maximum	
Skilled Nursing Facility	$10,000 Calendar Year Maximum	
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Serious Mental Illness, Mental Health Care, Treatment of Chemical Dependency *All services must be preauthorized* **Inpatient Services** (Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center)		
Hospital Services (facility)	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
Physician Services	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Outpatient Services		
All services must be preauthorized Services performed during Physician office visit (does not Include psychological testing)	100% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible
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Calendar Year Maximum	$15,000 max benefit for donor search & acceptability testing of potential live donors	
Three-month deductible carryover applies. Credit for Deductible Out-of-Pocket Maximum from prior carrier applied on initial group enrollment only.		

PRESCRIPTION DRUG BENEFIT SCHEDULE

	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy (Benefit payment are based on a 30-Day supply – with appropriate prescription order, up to a 90-day supply available)	100% of Allowable Amount after Deductible	
Mail Order Pharmacy (Benefit payment are based on a 30-Day supply – with appropriate prescription order, up to a 90-day supply available)	100% of Allowable Amount after Deductible	

Vaccinations obtained through pharmacies $15 copayment, deductibles do not apply.

MAC 1 Option – MAC 1 means there is no penalty or pricing differential if the member chooses the brand name drug when generic is available.

OTC Omeprazole 20 mg covered under the plan. All other OTC meds are not covered.

Diabetic supplies are covered under the plan.