

2017 Schedule of Benefits

	HMO Benefits	POS Benefits		HDHP Benefits	
	Network	Network	Non-Network	Network	Non-Network
Benefit Period Deductible (Single/Family)	\$500/\$1,500	\$500/\$1,500	\$1,000/\$3,000	\$2,000/\$4,000	\$4,500/\$9,000
Out of Pocket Maximum (Single/Family)	\$2,500/\$5,000	\$2,500/\$5,000	\$6,000/\$12,000	\$2,000/\$4,000	\$8,500/\$17,000
Physicians Office Visit	\$25.00 per visit	\$25.00 per visit	70%/30%	100% after deductible	70% after deductible
Specialist Office Visit	\$35.00 per visit	\$35.00 per visit	70%/30%	100% after deductible	70% after deductible
Allied Health Professionals					
Chiropractor	\$25.00 per visit	\$25.00 per visit	70%/30%	100% after deductible	70% after deductible
Physician's Assistant	\$25.00 per visit	\$25.00 per visit	70%/30%	100% after deductible	70% after deductible
Rehabilitative Care	80%/20%	80%/20%	70%/30%	100% after deductible	70% after deductible
Preventive/Wellness	\$0	\$0	70%/30%	0%	70%/30%
Employee Assistance Counseling	3 Visits (No Copay/Coinsurance)	3 Visits (No Copay/Coinsurance)	70%/30%	100% after deductible	70% after deductible
Urgent Care Center	\$40.00 per visit	\$40.00 per visit	70%/30%	100% after deductible	70% after deductible
Vision Care Exam (1 per 24 Months)	\$35.00 per visit	\$35.00 per visit	\$35.00 per visit	Not Covered	Not Covered
Refractive Errors of Eye	50%/50%	50%/50%	Not Covered	Not Covered	Not Covered
Emergency Room	\$150 (waived if admitted)	\$150 (waived if admitted)	\$150 (waived if admitted)	100% after deductible	70% after deductible
Ambulance Services	\$100 per day per Provider	\$100 per day per Provider	70%/30%	100% after deductible	70% after deductible
Air Ambulance Services	\$200 per day per Provider	\$200 per day per Provider	70%/30%	100% after deductible	70% after deductible
Ambulatory Surgical Facility	\$200 per Surgical visit	\$200 per Surgical visit	70%/30%	100% after deductible	70% after deductible
Physicians Outpatient Surgical Services	\$100 Copay per Day	\$100 Copay per Day	70%/30%	100% after deductible	70% after deductible
Inpatient Hospital Admission	\$200 per day/5 day Max	\$200 per day/5 day Max	70%/30%	100% after deductible	70% after deductible
Pregnancy Care	\$50 Copay (first visit only)	\$50 Copay (first visit only)	70%/30%	100% after deductible	70% after deductible
Durable Medical Equipment	80%/20% (\$25,000 max)	80%/20% (\$25,000 max)	70%/30%	100% after deductible	70% after deductible
Home Health Care	100%	100%	70%/30%	100% after deductible	70% after deductible
Hospice (limit 185 days)	100%	100%	70%/30%	100% after deductible	70% after deductible
Skilled Nursing Facility (limit 100 days)	100%	100%	70%/30%	100% after deductible	70% after deductible
Speech Therapy	80%/20%	80%/20%	70%/30%	100% after deductible	70% after deductible
Organ, Tissue, and Bone Marrow Trans.	Same as any other illness	Same as any other illness	None	100% after deductible	70% after deductible
Mental Disorders/Alcohol/Drug Abuse					
<i>Outpatient Mental Health and Substance Abuse Benefits</i>	100%	100%	70%/30%	100%	70%
<i>Inpatient Mental Health and Substance Drug Abuse Benefits</i>	100%	100%	70%/30%	100%	70%
<i>Inpatient Hospital Copayments and/or Inpatient Coinsurance amounts for Mental Health and Substance Abuse</i>	Payable same as medical benefits	Payable same as medical benefits	Payable same as medical benefits	Payable same as medical benefits	Payable same as medical benefits
Prescription Drug (Generic & Brand)	See attached Prescription Plan for HMO and POS			100 % after deductible	

****This is not intended to be comprehensive. The terms and conditions of the contract will prevail.****