BRIEF OVERVIEW OF MEDICAL BENEFITS

IMPORTANT NOTE: *For a more complete explanation of benefits you MUST refer to the Schedule of Medical Benefits, Exclusions, and Definitions chapters.*
Overall Annual Medical Plan Maximum: $2,000,000 per person per Plan year. Precertification is required on medical services over $1,000 and elective admissions.
Deductible applies to all services except where noted.
REMINDER: Except in an emergency, Out-of-Network claims are paid in accordance with the Plan's definition of Allowed Charge.

Medical Services	Premier Plan		Basic Plus Plan
	In-Network Benefits Preferred PPO Providers	Out-of-Network Non-Preferred Providers	Preferred PPO Providers ONLY
Out-of-Pocket Maximum: Applies to coinsurance. Does not accumulate copays, deductibles, precertification penalties, charges over the Allowed Charge, non-covered benefits, outpatient Rx drugs or wellness services over $300/yr.	$3,000 per person/plan yr. $6,000 per family/plan yr.	Unlimited (No out-of-pocket maximum)	$6,000 per person/plan yr. $12,000 per family/plan yr.
Deductible per person per plan year	$300/person $600/family		$600/person $1,200/family
Inpatient Hospital or Outpatient Surgical Facility	80%	60%	60%
Emergency Room, Emergency Inpatient Admission, Urgent Care or Ambulance (ER copay waived if admitted into hospital. Deductible applies to all benefits listed in this row.)	ER Facility: $100 copay then plan pays 80%. Urgent Care Facility: 80% Ambulance: 80%. ER/Urgent Care physician services: 80%.	ER Facility: $100 copay then plan pays 80%. Urgent Care Facility: 60%. Ambulance: 80%. ER/Urgent Care physician services: 80%	ER Facility: $100 copay then plan pays 60%. Urgent Care Facility: 60%. Ambulance: 60%. ER/Urgent Care physician services: 60%.
Primary Care Physician (PCP) Office Visits	$20 copay, no deductible	60%	60%
Other Physician Office Visits	80%	60%	60%
Wellness/Routine Physical for Employees & Dependents 19 months and older: The first $300 per person per plan year is paid as noted to the right, then, after deductible met, Plan pays 10% of eligible expenses and these eligible expenses do not accumulate to the out-of-pocket maximum.	100%, no deductible	100%, no deductible	100%, no deductible
Well Baby Exam: (birth through 18 months)	100%, no deductible after $20 copay/visit	100%, no deductible, after $20 copay/visit	100%, no deductible after $20 copay/visit
Immunizations for Children and Adults	100%, no deductible	100%, no deductible	100%, no deductible
Outpatient X-rays, Surgeon fees, Anesthesia Fees, Allergy Injections	80%	60%	60%
Outpatient Laboratory services	Hospital based lab: 80%, after deductible met Non-hospital based lab: 100%, no deductible	60%, after deductible met	Hospital based lab: 60%, after deductible met Non-hospital based lab: 100%, no deductible
Alternative Health Care Services (Acupuncture, Naturopathic and/or Chiropractic Services) payable to a max. of $600/plan yr.	80%	60%	60%
Physical & Occupational Therapy max $5,000 per injury or illness. Speech Therapy max $500 per plan yr.	80%	60%	60%
Certified Nurse Midwife max $1,000/pregnancy	80%	60%	60%
Durable Medical Equipment max. $5,000 per person per plan yr. Oxygen equipment/supplies max. $3,000 per person per plan yr.	80%	60%	60%
Hearing Exams and Hearing Aides max $1,500/person once every 3 years	80%	60%	60%
Home Health Services max. 60 days per plan year	80%	60%	60%
Behavioral Health: up to 3 free visits/problem/person.	Outpatient: 100% after $20 copay per visit, no deductible. Inpatient: 80%	Outpatient or Inpatient: 60%	Outpatient or Inpatient: 60%

Outpatient Prescription Drug Benefits	Premier Plan or the Basic Plus Plan
No deductible. If the actual cost of the drug is less than the copay or coinsurance, you pay the actual drug cost.	In-Network Retail Pharmacy (up to a 30-day supply, no deductible): *Generic:* $10 copay, *Preferred Brand*: 20% of the cost of the drug to a maximum of $100 copay per fill, *Non-Preferred Brand*: 50% of the cost of the drug with a $20 minimum and $150 copay maximum per fill. In-Network Retail Pharmacy (up to a 90-day supply, no deductible): *Generic:* $30 copay, *Preferred Brand*: 20% of the cost of the drug to a maximum of $300 copay per fill, *Non-Preferred Brand*: 50% of the cost of the drug with a $60 minimum and $450 copay maximum per fill. Mail Order (up to 90-day supply, no deductible): *Generic:* $15 copay, P*referred Brand:* $40 copay, *Non-Preferred Brand*: $100 copay