

Program Basics	EPO (In-Network)	Non-EPO (Out-of-Network)
Overall Lifetime Benefit Maximum Per individual		\$2,000,000
Other Lifetime Benefit Maximums		\$50,000
Morbid Obesity Surgery, including complications		\$1,000
TMJ Treatment		\$500
Wigs (for hair loss due to chemotherapy or radiation)		\$500
Deductibles	\$0	Not applicable
Per Person Out-of-Pocket Maximum*	\$2,000	Not applicable
Per Person Plus One Out-of-Pocket Maximum*	\$4,000	Not applicable
Per Family Unit Out-of-Pocket Maximum*	\$5,000	Not applicable
<p>*The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items do not apply to the out-of-pocket (OOP) maximums: Prescription copayments, vision & dental benefits and services excluded from coverage. The per person plus one OOP maximum is equal to two individual OOP maximums and the family unit OOP maximum is equal to 2 1/2 individual OOP maximums.</p>		
Prescription Drug Card (Retail and Mail Order)	Retail Copay: \$10 / 30 / 50 Mail Copay: \$20 / 60 / 100	Not covered
Physician Services		
Physician Office Visits Includes surgeries, therapies and certain diagnostic procedures performed in a physician's office.	\$30 copay, then 100%	Not covered
Well Adult Care (age 16 and over) Includes benefits for routine physical examinations, immunizations and routine diagnostic tests. Limited to one physical exam plus one gynecological exam per calendar year.	\$30 copay, then 100%.	Not covered
Preventive mammograms.	100%-no copay/deductible	Not covered
Well Child Care (to age 16) Coverage for physical exams, immunizations and routine diagnostic tests.	\$30 copay, then 100%	Not covered
Maternity Physician Services Maternity physician covered services are paid the same as Medical/Surgical Services.	\$30 copay, then 100%	Not covered
Medical/Surgical Physician Services Includes surgical procedures, inpatient visits, allergy injections or treatments, certain diagnostic procedures as well as other physician services.	100%	Not covered
Mental Health/Substance Abuse Physician Services Mental health and substance abuse physician services are paid the same as Medical/Surgical Services.	\$30 copay, then 100%	Not covered

Program Basics	EPO (In-Network)	Non-EPO (Out-of-Network)
Hospital Services		
Inpatient Hospital Services Includes room and board, general nursing care, ICU, operating and recovery rooms, anesthesia, inpatient rehabilitation, mental health/substance abuse, and hospice, and other services and supplies. Inpatient hospital services require prior authorization.	\$400 copay per admit, then 100%	Not covered
Skilled Nursing Facility Services Includes short-term, non-custodial care in a skilled nursing facility up to a maximum of 120 days per calendar year. Requires prior authorization.	100%	Not covered
Outpatient Hospital Services Includes, but is not limited to, outpatient or ambulatory surgical procedures performed in a hospital or ambulatory surgical center.	\$100 copay per procedure, then 100%	Not covered
Outpatient Emergency Care (Injury or Illness)	\$125 copay, then 100%	
Additional Services		
Outpatient Rehabilitation Therapy Services Includes physical, occupational and/or speech therapy services provided in an outpatient or home setting.	\$30 copay, then 100%	Not covered
Home Health Services Includes home health and home infusion services up to a maximum of 100 visits per benefit year.	\$30 copay, then 100%	Not covered
Other Covered Services Includes durable medical equipment, prosthetics, private duty nursing (outpatient or home only), autism spectrum disorder services for children birth to 21.	100%	Not covered

		Dental Plan
Deductible Per Calendar Year		\$50 Employee only \$100 Employee + 1 \$150 Employee + 2 or more
Calendar Year Maximum		Per covered individual
Active employee or Retiree		\$1,000
	Services	
Type A		Deductible waived
Preventative Care		You pay 0%
Oral Exams, X-rays, Etc		
Type B		Deductible Applies
Basic Care		You pay 20%
Restorative Type Fillings,		
Extractions, Etc		
Type C		Deductible Applies
Major Restorative		You pay 20%
Inlays, Onlays,		
Gold Fillings, Crowns,		
Partials, Dentures, Etc.		
Orthodontic Services or supplies are not covered		

Vision Benefits			
for Active Employees and Retirees and their qualified Dependents			
	<i>One Lens</i>		<i>One Set</i>
		Maximum Plan Payment	
Benefits:			
Lens or Lenses			
Single Vision	\$14.50		\$29.00
Bifocal	\$21.75		\$43.50
Tifocal	\$29.00		\$58.00
Lenticular	\$36.30		\$72.60
Contact	\$21.75		\$43.50
Frames			\$20.60
Exam - Optometrist			\$29.00
Exam - Ophthalmologist			\$36.30