PLAN #1
FAMILY $335.84/MO.
SINGLE $134.33/MO

* HSA NOT AN OPTION

OUTLINE OF BENEFITS

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Annual Deductible Amount amounts do not credit	$500 per participant, not to exceed $1,000 per family	$1,000 per participant, not to exceed $2,000 per family
Annual Out-Of-Pocket Limit limits do not credit	$500 per participant, not to exceed $1,000 per family	$1,400 per participant, not to exceed $2,800 per family
Maximum Annual Out-of-Pocket Limit	$6,850 per participant, not to exceed $13,700 per family	Not Applicable
Dependent Coverage Ends	The day immediately following the last day of the month in which the dependent turns age 26	
Professional Services		
Office Visits – Evaluation and Management charge only All other services provided during the office visit	$20 Copayment for primary care or $50 copayment for specialty, plus deductible, then100% of charges Deductible, then 100% of charges	$20 Copayment for primary care or $50 copayment for specialty, plus deductible, then 80% of charges Deductible, then 80% of charges
Chiropractic Services – Office Visits and Manipulation charges only All other services or therapies provided during the chiropractic visit	$50.00 Copayment, plus deductible, then100% of charges Deductible, then 100% of charges	$50 Copayment, plus deductible, then 80% of charges Deductible, then 80% of charges
Surgical Services, including surgery for morbid obesity Does not include transplants and oral surgery	Deductible, then 100% of charges	Deductible, then 80% of charges
Oral Surgical Services (limited to 13 surgeries listed in the Plan)	Deductible, then 100% of charges	Deductible, then 80% of charges
Anesthesia Services (other than anesthesia provided by an independent anesthesiologist)	Deductible, then 100% of charges	Deductible, then 80% of charges
Diagnostic X-Ray and Lab (other than x-rays and labs provided by an independent radiologist or pathologist)	Deductible, then 100% of charges	Deductible, then 80% of charges
Anesthesia, X-rays and Labs provided by independent anesthesiologists, radiologists and pathologists	Deductible, then 100% of charges	Deductible, then 100% of charges
Radiation and Chemotherapy	Deductible, then 100% of charges	Deductible, then 80% of charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Hospital Services (does not apply to alcoholism, drug abuse or nervous or mental disorders)		
Emergency Room/Urgent Care Services: Facility Charge only	$100 Copayment, then deductible, 100% of charges	$100 Copayment, then preferred deductible, 100% of charges
All other services provided during the ER/urgent care visit	Deductible, then 100% of charges	Preferred deductible, then 100% of charges
Hospital Services	Deductible, then 100% of charges	Deductible, then 80% of charges
Maternity Services	Deductible, then 100% of charges	Deductible, then 80% of charges
In order to receive full Plan benefits, prior authorization is required on all inpatient confinements. See section "OBTAINING SERVICES."		
Preventive Services - includes screenings as required by the United States Preventive Services Task Force (USPSTF)		
Immunizations	100% of charges (deductible waived)	
Routine Exams - includes eye and hearing exams, pelvic exams Related diagnostic services *(also includes well baby care)*	100% of charges	$20.00 Copayment, then deductible, 80% of charges Deductible, then 80% of charges
Mammograms and Pap Smears	100% of charges	Deductible, then 80% of charges
Routine Colonoscopy – One per participant every five years	100% of charges	Deductible, then 80% of charges
Other Covered Health Care Services		
Outpatient Physical, Speech, Massage, Occupational and Respiratory Therapy	Deductible, then 100% of charges	Deductible, then 80% of charges
Professional Ambulance	Deductible, then 100% of charges	Preferred deductible, then 100% of charges
Prosthetics	Deductible, then 100% of charges	Deductible, then 80% of charges
Orthotic Devices (Casts, Splints, Orthopedic Braces, Custom-Molded Foot Orthotics)	Deductible, then 100% of charges	Deductible, then 80% of charges
Medical Supplies	Deductible, then 100% of charges	Deductible, then 80% of charges
Durable Medical Equipment	Deductible, then 100% of charges	Deductible, then 80% of charges
Dental Extraction for the Initial Replacement of Natural Teeth	Deductible, then 100% of charges	Deductible, then 80% of charges
Outpatient Cardiac Rehabilitation	Deductible, then 100% of charges	Deductible, then 80% of charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Limited to 48 sessions per covered illness		
Contraceptives for Birth Control *Limited to those which require a physician's intervention*	Deductible, then 100% of charges	Deductible, then 80% of charges
Licensed Skilled Nursing Facility *Limited to 60 days per confinement*	Deductible, then 100% of charges	Deductible, then 80% of charges
Home Care Services *Limited to 40 days per calendar year*	Deductible, then 100% of charges	Deductible, then 80% of charges
Equipment and Supplies for Diabetes (excludes insulin)	Deductible, then 100% of charges	Deductible, then 80% of charges
Mammograms and Pap Smears	Deductible, then 100% of charges	Deductible, then 80% of charges
Transplants	Deductible, then 100% of charges	Not Covered
Temporomandibular Joint Disorders *non-surgical services are limited to $1,250 per calendar year*	Deductible, then 100% of charges	Deductible, then 80% of charges
Autism Services *Subject to limits as stated in the Plan*	Deductible, then 100% of charges	Deductible, then 80% of charges
Hearing Aids and Cochlear Implants for Covered Children under age 18 *Limited to one hearing aid per ear every three years*	Deductible, then 100% of charges	Deductible, then 80% of charges
Hospice Care	Deductible, then 100% of charges	Deductible, then 80% of charges
Nutritional Counseling	100% of charges	Deductible, then 80% of charges
Genetic Testing and Counseling for Breast and Ovarian Cancer Susceptibilty	100% of charges	Deductible, then 80% of charges
Behavioral Health Services		
Inpatient Hospital Services for Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then100% of charges	Deductible, then 80% of charges
Outpatient Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then 100% of charges Therapy subject to $20.00 Copayment, plus deductible, then 100% of charges	Deductible, then 80% of charges Therapy subject to $20 copayment, then payable at 80% of the charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Transitional Treatment Arrangements for Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then 100% of charges	Deductible, then 80% of charges

Prescription Legend Drugs (includesLymerix syringes and Tamiflu)	
Copayments for Retail and Home Delivery	$5.00 for generic drugs $25.00 for preferred brand-name drugs $50.00 for brand name drugs 25% up to $250 for specialty drugs $100 maximum copayment for chemotherapy drugs $0.00 for insulin
Contraceptives – including, but not limited to oral and patch; vaginal rings and diaphragms	Covered - not subject to copayments
Preventive drugs as defined in the Plan	Covered - not subject to copayments
Mandatory Generic	Applicable
Limitations	Retail: a 30-day supply at one time Home Delivery: a 90-day supply at one time Specialty drugs: a 30-day supply at one time Covered drugs for smoking cessation: a 180-day supply of one nicotine replacement and/or covered drugs per participant per calendar year

THIS OUTLINE IS MEANT AS A SUMMARY DESCRIPTION OF BENEFIT COVERAGE ONLY. IT CAN NOT ADD TO OR TAKE AWAY BENEFITS SINCE COVERAGE IS SUBJECT TO THE TERMS AND CONDITIONS OF THE PLAN.

THE TERM "CHARGES" AS USED IN THIS OUTLINE MEANS THE AMOUNT THAT THE CLAIM ADMINISTRATOR DETERMINES AS REASONABLE FOR THE HEALTH CARE SERVICE

PLAN #2
FAMILY $180.82/mo.
SINGLE $72.32/mo.
* HSA Not An Option

OUTLINE OF BENEFITS

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Annual Deductible Amount amounts do not credit	$1,000 per participant, not to exceed $2,000 per family	$2,000 per participant, not to exceed $4,000 per family
Annual Deductible and Coinsurance Out-Of-Pocket Limit limits do not credit	$1,000 per participant, not to exceed $2,000 per family	$2,400 per participant, not to exceed $4,800 per family
Maximum Annual Out-of-Pocket Limit	$6,850 per participant, not to exceed $13,700 per family	Not Applicable
Dependent Coverage Ends	The day immediately following the last day of the month in which the dependent turns age 26	
Professional Services		
Office Visits – Evaluation and Management charge only All other services provided during the office visit	$20 Copayment for primary care or $50 copayment for specialty, plus deductible, then100% of charges Deductible, then 100% of charges	$20 Copayment for primary care or $50 copayment for specialty, plus deductible, then 80% of charges Deductible, then 80% of charges
Chiropractic Services – Office Visits and Manipulation charges only All other services or therapies provided during the chiropractic visit	$50 Copayment, plus deductible, then 100% of charges Deductible, then 100% of charges	$50 Copayment, plus deductible, then 80% of charges Deductible, then 80% of charges
Surgical Services, including surgery for morbid obesity Does not include transplants and oral surgery	Deductible, then 100% of charges	Deductible, then 80% of charges
Oral Surgical Services (limited to 13 surgeries listed in the Plan)	Deductible, then 100% of charges	Deductible, then 80% of charges
Anesthesia Services (other than anesthesia provided by an independent anesthesiologist)	Deductible, then 100% of charges	Deductible, then 80% of charges
Diagnostic X-Ray and Lab (other than x-rays and labs provided by an independent radiologist or pathologist)	Deductible, then 100% of charges	Deductible, then 80% of charges
Anesthesia, X-rays and Labs provided by independent anesthesiologists, radiologists and pathologists	Deductible, then 100% of charges	Deductible, then 100% of charges
Radiation and Chemotherapy	Deductible, then 100% of charges	Deductible, then 80% of charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Hospital Services (does not apply to alcoholism, drug abuse or nervous or mental disorders)		
Emergency Room/Urgent Care Services: Facility Charge only	$100 Copayment, then deductible, 100% of charges	$100 Copayment, then preferred deductible, 100% of charges
All other services provided during the ER/urgent care visit	Deductible, then 100% of charges	Preferred deductible, then 100% of charges
Hospital Services	Deductible, then 100% of charges	Deductible, then 80% of charges
Maternity Services	Deductible, then 100% of charges	Deductible, then 80% of charges
In order to receive full Plan benefits, prior authorization is required on all inpatient confinements. See section "OBTAINING SERVICES."		
Preventive Services - includes screenings as required by the United States Preventive Services Task Force (USPSTF)		
Immunizations	100% of charges (deductible waived)	
Routine Exams - includes eye and hearing exams, pelvic exams Related diagnostic services *(also includes well baby care)*	100% of charges	$20.00 Copayment, then deductible, 80% of charges Deductible, then 80% of charges
Mammograms and Pap Smears	100% of charges	Deductible, then 80% of charges
Routine Colonoscopy – One per participant every five years	100% of charges	Deductible, then 80% of charges
Other Covered Health Care Services		
Outpatient Physical, Speech, Massage, Occupational and Respiratory Therapy	Deductible, then 100% of charges	Deductible, then 80% of charges
Professional Ambulance	Deductible, then 100% of charges	Preferred deductible, then 100% of charges
Prosthetics	Deductible, then 100% of charges	Deductible, then 80% of charges
Orthotic Devices (Casts, Splints, Orthopedic Braces, Custom-Molded Foot Orthotics)	Deductible, then 100% of charges	Deductible, then 80% of charges
Medical Supplies	Deductible, then 100% of charges	Deductible, then 80% of charges
Durable Medical Equipment	Deductible, then 100% of charges	Deductible, then 80% of charges
Dental Extraction for the Initial Replacement of Natural Teeth	Deductible, then 100% of charges	Deductible, then 80% of charges
Outpatient Cardiac Rehabilitation	Deductible, then 100% of charges	Deductible, then 80% of charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Limited to 48 sessions per covered illness		
Contraceptives for Birth Control *Limited to those which require a physician's intervention*	Deductible, then 100% of charges	Deductible, then 80% of charges
Licensed Skilled Nursing Facility *Limited to 60 days per confinement*	Deductible, then 100% of charges	Deductible, then 80% of charges
Home Care Services *Limited to 40 days per calendar year*	Deductible, then 100% of charges	Deductible, then 80% of charges
Equipment and Supplies for Diabetes (excludes insulin)	Deductible, then 100% of charges	Deductible, then 80% of charges
Mammograms and Pap Smears	Deductible, then 100% of charges	Deductible, then 80% of charges
Transplants	Deductible, then 100% of charges	Not Covered
Temporomandibular Joint Disorders *non-surgical services are limited to $1,250 per calendar year*	Deductible, then 100% of charges	Deductible, then 80% of charges
Autism Services *Subject to limits as stated in the Plan*	Deductible, then 100% of charges	Deductible, then 80% of charges
Hearing Aids and Cochlear Implants for Covered Children under age 18 *Limited to one hearing aid per ear every three years*	Deductible, then 100% of charges	Deductible, then 80% of charges
Hospice Care	Deductible, then 100% of charges	Deductible, then 80% of charges
Nutritional Counseling	100% of charges	Deductible, then 80% of charges
Genetic Testing and Counseling for Breast and Ovarian Cancer Susceptibilty	100% of charges	Deductible, then 80% of charges
Behavioral Health Services		
Inpatient Hospital Services for Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then100% of charges	Deductible, then 80% of charges
Outpatient Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then100% of charges Therapy subject to $20.00 Copayment, plus deductible, then 100% of charges	Deductible, then 80% of charges Therapy subject to $20 copayment, then payable at 80% of the charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Transitional Treatment Arrangements for Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then 100% of charges	Deductible, then 80% of charges

Prescription Legend Drugs (includesLymerix syringes and Tamiflu)	
Copayments for Retail and Home Delivery	$5.00 for generic drugs $25.00 for preferred brand-name drugs $50.00 for brand name drugs 25% up to $250 for specialty drugs $100 maximum copayment for chemotherapy drugs $0.00 for insulin
Contraceptives – including, but not limited to oral and patch; vaginal rings and diaphragms	Covered - not subject to copayments
Preventive drugs as defined in the Plan	Covered - not subject to copayments
Mandatory Generic	Applicable
Limitations	Retail: a 30-day supply at one time Home Delivery: a 90-day supply at one time Specialty drugs: a 30-day supply at one time Covered drugs for smoking cessation: a 180-day supply of one nicotine replacement and/or covered drugs per participant per calendar year

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PLAN #3

FAMILY $74.70/mo.

SINGLE $29.88/mo.

* HSA Option

OUTLINE OF BENEFITS

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Annual Deductible Amount amounts do not credit	$1,300 for single coverage, $2,600 for family coverage	$2,600 for single coverageт, $5,200 for family coverage
Annual Out-Of-Pocket Limit limits do not credit	$1,300 for single coverage,$2,600 for family coverage	$3,600 for single coverage,$7,200 for family coverage
Dependent Coverage Ends	The day immediately following the last day of the month in which the dependent turns age 26	
Professional Services		
Office Visits – Evaluation and Management charge only All other services provided during the office visit	Deductible, then100% of charges Deductible, then 100% of charges	Deductible, 80% of charges Deductible, then 80% of charges
Chiropractic Services – Office Visits and Manipulation charges only All other services or therapies provided during the chiropractic visit	Deductible, 100% of charges Deductible, then 100% of charges	Deductible, 80% of charges Deductible, then 80% of charges
Surgical Services, including surgery for morbid obesity Does not include transplants and oral surgery	Deductible, then 100% of charges	Deductible, then 80% of charges
Oral Surgical Services (limited to 13 surgeries listed in the Plan)	Deductible, then 100% of charges	Deductible, then 80% of charges
Anesthesia Services (other than anesthesia provided by an independent anesthesiologist)	Deductible, then 100% of charges	Deductible, then 80% of charges
Diagnostic X-Ray and Lab (other than x-rays and labs provided by an independent radiologist or pathologist)	Deductible, then 100% of charges	Deductible, then 80% of charges
Anesthesia, X-rays and Labs provided by independent anesthesiologists, radiologists and pathologists	Deductible, then 100% of charges	Deductible, then 100% of charges
Radiation and Chemotherapy	Deductible, then 100% of charges	Deductible, then 80% of charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Hospital Services (does not apply to alcoholism, drug abuse or nervous or mental disorders)		
Emergency Room/Urgent Care Services: Facility Charge only All other services provided during the ER/urgent care visit	Deductible, 100% of charges Deductible, then 100% of charges	Preferred deductible, 100% of charges Preferred deductible, then 100% of charges
Hospital Services	Deductible, then 100% of charges	Deductible, then 80% of charges
Maternity Services	Deductible, then 100% of charges	Deductible, then 80% of charges
In order to receive full Plan benefits, prior authorization is required on all inpatient confinements. See section "OBTAINING SERVICES."		
Preventive Services - includes screenings as required by the United States Preventive Services Task Force (USPSTF)		
Immunizations	100% of charges (deductible waived)	
Routine Exams - includes eye and hearing exams, pelvic exams Related diagnostic services *(also includes well baby care)*	100% of charges	Deductible, 80% of charges Deductible, then 80% of charges
Mammograms and Pap Smears	100% of charges	Deductible, then 80% of charges
Routine Colonoscopy – One per participant every five years	100% of charges	Deductible, then 80% of charges
Other Covered Health Care Services		
Outpatient Physical, Speech, Massage, Occupational and Respiratory Therapy	Deductible, then 100% of charges	Deductible, then 80% of charges
Professional Ambulance	Deductible, then 100% of charges	Preferred deductible, then 100% of charges
Prosthetics	Deductible, then 100% of charges	Deductible, then 80% of charges
Orthotic Devices (Casts, Splints, Orthopedic Braces, Custom-Molded Foot Orthotics)	Deductible, then 100% of charges	Deductible, then 80% of charges
Medical Supplies	Deductible, then 100% of charges	Deductible, then 80% of charges
Durable Medical Equipment	Deductible, then 100% of charges	Deductible, then 80% of charges
Dental Extraction for the Initial Replacement of Natural Teeth	Deductible, then 100% of charges	Deductible, then 80% of charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Outpatient Cardiac Rehabilitation *Limited to 48 sessions per covered illness*	Deductible, then 100% of charges	Deductible, then 80% of charges
Contraceptives for Birth Control *Limited to those which require a physician's intervention*	Deductible, then 100% of charges	Deductible, then 80% of charges
Licensed Skilled Nursing Facility *Limited to 60 days per confinement*	Deductible, then 100% of charges	Deductible, then 80% of charges
Home Care Services *Limited to 40 days per calendar year*	Deductible, then 100% of charges	Deductible, then 80% of charges
Equipment and Supplies for Diabetes (excludes insulin)	Deductible, then 100% of charges	Deductible, then 80% of charges
Mammograms and Pap Smears	Deductible, then 100% of charges	Deductible, then 80% of charges
Transplants	Deductible, then 100% of charges	Not Covered
Temporomandibular Joint Disorders *non-surgical services are limited to $1,250 per calendar year*	Deductible, then 100% of charges	Deductible, then 80% of charges
Autism Services *Subject to limits as stated in the Plan*	Deductible, then 100% of charges	Deductible, then 80% of charges
Hearing Aids and Cochlear Implants for Covered Children under age 18 *Limited to one hearing aid per ear every three years*	Deductible, then 100% of charges	Deductible, then 80% of charges
Hospice Care	Deductible, then 100% of charges	Deductible, then 80% of charges
Nutritional Counseling	100% of charges	Deductible, then 80% of charges
Genetic Testing and Counseling for Breast and Ovarian Cancer Susceptibilty	100% of charges	Deductible, then 80% of charges
Behavioral Health Services		
Inpatient Hospital Services for Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then100% of charges	Deductible, then 80% of charges
Outpatient Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then100% of charges	Deductible, then 80% of charges

Provision/Benefit	Preferred Provider	Non-Preferred Provider
Transitional Treatment Arrangements for Alcoholism, Drug Abuse and Nervous or Mental Disorders	Deductible, then100% of charges	Deductible, then 80% of charges

Prescription Legend Drugs (includesLymerix syringes and Tamiflu)	
Retail and Home Delivery	Preferred deductible, then 100% of charges
Contraceptives – including, but not limited to oral and patch; vaginal rings and diaphragms	Covered - 100% - not subject to deductible
Preventive drugs as defined in the Plan	Covered – 100% - not subject to deductible
Mandatory Generic	Applicable
Limitations	Retail: a 30-day supply at one time Home Delivery: a 90-day supply at one time Specialty drugs: a 30-day supply at one time Covered drugs for smoking cessation: a 180-day supply of one nicotine replacement and/or covered drugs per participant per calendar year

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