

Benefits Summary - Effective May 15, 2017

Benefit	Plan I		Plan II	
	In-Network Provider	Out-of-Network Provider	In-Network Provider	Out-of-Network Provider
Hospital				
Calendar Year Deductible	The Industry Health Network - \$150 / person; \$300 / family BlueCard PPO/Beacon Health Options - \$250 / person; \$500 / family	Not covered	The Industry Health Network - \$150 / person; \$300 / family BlueCard PPO/Beacon Health Options - \$500 / person; \$1,000 / family	Not covered
Inpatient (Room and Board and Ancillary Services)	90% after \$100 copay	Not covered*	80% after \$100 copay	Not covered*
Outpatient Surgery	90% after \$100 copay	Not covered	80% after \$100 copay	Not covered
Emergency Room	90% after \$100 copay; emergency room copay is waived if immediately confined	Not covered*	80% after \$100 copay; emergency room copay is waived if immediately confined	Not covered*
Coinsurance Out-of-Pocket Limit	\$1,750 / person; \$3,500 / family	Not covered	\$2,000 / person; \$4,000 / family	Not covered
Medical				
Calendar Year Deductible	The Industry Health Network - None BlueCard PPO/Beacon Health Options - \$250 / person; \$500 / family	\$500 / person; \$1,000 / family	The Industry Health Network - None BlueCard PPO/Beacon Health Options - \$500 / person; \$1,000 / family	\$1,000 / person; \$2,000 / family
Office Visit	No deductible; 100% after \$25 copay	70%	No deductible; 100% after \$25 copay	60%
Surgeon	90%	70%	80%	60%
X-ray and Lab	90%	70%	80%	60%
Therapy (Occupational, Osteopathic, Physical, Speech, Vision)	90%	70%	80%	60%
Maternity Care -				
Prenatal Visits	No deductible; 100%	70%	No deductible; 100%	60%
Delivery	90%	70%	80%	60%
Routine Physical Exam	No deductible; 100%	70%	No deductible; 100%	60%
Routine Child Exam	No deductible; 100%	70%	No deductible; 100%	60%
Routine Mammogram/Pap	No deductible; 100%	70%	No deductible; 100%	60%
Hearing Aids	90% up to a maximum payment of \$1,500 per device; one device per ear per three-year period	70% up to a maximum payment of \$1,500 per device; one device per ear per three-year period	80% up to a maximum payment of \$1,000 per device; one device per ear per three-year period	60% up to a maximum payment of \$1,000 per device; one device per ear per three-year period
Coinsurance Out-of-Pocket Limit	\$1,000 / person; \$2,000 / family	\$2,500 / person; \$5,000 / family	\$1,200 / person; \$2,400 / family	\$3,000 / person; \$6,000 / family
Hospital / Medical / Rx Out-of-Pocket Maximum (includes Deductibles, Copays, Coinsurance)	\$7,150 / person; \$14,300 / family	None	\$7,150 / person; \$14,300 / family	None

*Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-Network Level of Benefits.

Benefits Summary (continued) - Effective May 15, 2017

Benefit	Plan I		Plan II	
Prescription Drugs	Express Scripts Participating Retail Pharmacy	Express Scripts Home Delivery (includes Specialty)	Express Scripts Participating Retail Pharmacy	Express Scripts Home Delivery (includes Specialty)
	Specialty medications must be obtained by mail through the specialty pharmacy, Accredo, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy or any Walgreens Network pharmacy beginning with the third fill. Non-formulary drugs are not covered.		Specialty medications must be obtained by mail through the specialty pharmacy, Accredo, beginning with the first fill. Long-term medications must be obtained by mail through the home delivery pharmacy or any Walgreens Network pharmacy beginning with the third fill. Non-formulary drugs are not covered.	
Calendar Year Deductible	\$75 / person; \$150 / family		\$175 / person; \$350 / family	
Supply	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill	Up to a 30 day supply / prescription or refill	Up to a 90 day supply / prescription or refill
Copay	The greater of:		The greater of:	
Generic	\$10 or 10%	\$20 or 10%; max copay is \$50 / prescription	\$10 or 10%	\$20 or 10%; max copay is \$50 / prescription
Preferred Brand	\$25 or 25%	\$50 or 25%; max copay is \$125 / prescription	\$25 or 25%	\$50 or 25%; max copay is \$125 / prescription
Non-Preferred Brand	\$40 or 40%	\$100 or 40%; max copay is \$300 / prescription	\$40 or 40%	\$100 or 40%; max copay is \$300 / prescription
	In addition, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication. Generic prescription contraceptives are covered at 100% with no deductible or copay.	In addition to the maximum copays listed above, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication. Generic prescription contraceptives are covered at 100% with no deductible or copay.	In addition, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication. Generic prescription contraceptives are covered at 100% with no deductible or copay.	In addition to the maximum copays listed above, if you receive a brand name drug when a generic exists, you will pay the difference in cost between the generic and brand name medication. Generic prescription contraceptives are covered at 100% with no deductible or copay.
Mental Health and Substance Abuse	Beacon Health Options Provider	Out-of-Network Provider	Beacon Health Options Provider	Out-of-Network Provider
Hospital and Alternative Levels of Care *	Covered under the Hospital Benefit	Not covered**	Covered under the Hospital Benefit	Not covered**
Medical	Covered under the Medical Benefit	Covered under the Medical Benefit	Covered under the Medical Benefit	Covered under the Medical Benefit
Dental	Delta Dental PPO Provider	Delta Premier and Out-of-Network Providers	Delta Dental PPO Provider	Delta Premier and Out-of-Network Providers
Calendar Year Deductible	\$75 / person; \$200 / family	\$75 / person; \$200 / family	\$100 / person; no family maximum	\$100 / person; no family maximum
Diagnostic and Preventive Benefits	No deductible; 100%	75%	No deductible; 100%	60%
Basic Benefits	75%	75%	60%	60%
Major Benefits	50%	50%	50%	50%
Calendar Year Maximum***	\$2,500	\$2,500	\$1,000	\$1,000
Vision - Exam Plus Plan	Vision Service Plan Provider	Out-of-Network Provider	Vision Service Plan Provider	Out-of-Network Provider
Eye Exams	100% after \$10 copay; one exam / calendar year	80% up to maximum payment of \$50; one exam / calendar year	Not covered	
Glasses	20% discount	No benefit		
Professional Services for Contact Lenses	15% discount	No benefit		

*Alternative levels of care include Residential Treatment Center, Partial Hospital Program and Intensive Outpatient Program.

**Emergency treatment within 72 hours after an accident or within 24 hours of a sudden and serious illness will be covered at the In-Network Level of Benefits.

***There is no dental maximum for individuals under age 19.