

2012 Benefits at a Glance

COVERED SERVICES	PARTNERSHIP PPO		STANDARD PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
NEW: For the following services, you do not need to meet your deductible first. These costs do not apply to your annual out-of-pocket coinsurance maximum. There is a separate co-pay out-of-pocket maximum for the following services.				
Preventive Care	No charge	\$45 co-pay	No charge	\$50 co-pay
Well-Baby, Well-Child Visits	No charge	\$45 co-pay	No charge	\$50 co-pay
Primary Care	\$25 co-pay	\$45 co-pay	\$30 co-pay	\$50 co-pay
Specialist Care	\$40 co-pay	\$65 co-pay	\$45 co-pay	\$70 co-pay
Mental Health and Substance Abuse [1] [2]	\$25 co-pay	\$45 co-pay	\$30 co-pay	\$50 co-pay
NEW: Out-of-Pocket Co-pay Maximum	\$900	none	\$1,100	none
For the following services, you do not need to meet your deductible first. These costs do not apply to your annual out-of-pocket coinsurance maximum.				
NEW: Convenience Clinics/Urgent Care Facilities	\$30 co-pay		\$35 co-pay	
Emergency Room (waived if admitted)	\$80 co-pay		\$100 co-pay	
X-ray, Lab and Diagnostics	100% covered after office co-pay	100% covered after office co-pay up to MAC	100% covered after office co-pay	100% covered after office co-pay up to MAC
Chiropractic (medical necessity criteria may apply)	Visits 1-20: \$25 Visits 21 and up: \$40	Visits 1-20: \$45 Visits 21 and up: \$65	Visits 1-20: \$30 Visits 21 and up: \$45	Visits 1-20: \$50 Visits 21 and up: \$70
Pharmacy (30-day supply only from pharmacies in the 30-day network)	\$5 co-pay generic; \$30 co-pay preferred brand; \$80 co-pay non-preferred brand	Co-pay plus any amount exceeding MAC	\$10 co-pay generic; \$40 co-pay preferred brand; \$90 co-pay non-preferred brand	Co-pay plus any amount exceeding MAC
Pharmacy (90-day supply only from special, less costly 90-day network or mail order)	\$10 co-pay generic; \$60 co-pay preferred brand; \$160 co-pay non-preferred brand	Co-pay plus any amount exceeding MAC	\$20 co-pay generic; \$80 co-pay preferred brand; \$180 co-pay non-preferred brand	Co-pay plus any amount exceeding MAC
NEW: Pharmacy (90-day supply for certain medications only from special, less costly 90-day network or mail order) [3]	\$5 co-pay generic; \$30 co-pay preferred brand	Co-pay plus any amount exceeding MAC	\$10 co-pay generic; \$40 co-pay preferred brand	Co-pay plus any amount exceeding MAC
For the following services, you must meet your deductible before the plan will begin to pay benefits. These costs apply to your annual out-of-pocket maximum.				
Inpatient Care (including mental health and substance abuse) [2]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Outpatient Surgery [2]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance (air and ground)	10% coinsurance		20% coinsurance	
Advanced X-ray, Scans and Imaging [2]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
OT/PT/Speech Therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance

Deductible				
Employee Only	\$350	\$700	\$700	\$1,400
NEW: Employee + Child(ren)	\$550	\$1,100	\$1,100	\$2,200
Employee + Spouse	\$700	\$1,400	\$1,400	\$2,800
Employee + Spouse + Child(ren)	\$900	\$1,800	\$1,800	\$3,600
Out-of-Pocket Maximum				
Employee Only	\$1,350	\$2,700	\$1,700	\$3,400
NEW: Employee + Child(ren)	\$2,150	\$4,300	\$2,800	\$5,600
Employee + Spouse	\$2,700	\$5,400	\$3,400	\$6,800
Employee + Spouse + Child(ren)	\$3,500	\$7,000	\$4,500	\$9,000

MAC stands for “maximum allowable charge.” The MAC is the most that a plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay the difference between the MAC and the actual charge.

[1] The following behavioral health services are treated as “inpatient” for the purpose of determining member cost-sharing: residential treatment, partial hospitalization, and intensive outpatient therapy.

[2] Prior Authorization required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if prior authorization is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

[3] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies; statins.

COVERED SERVICES	LIMITED PPO	
	IN-NETWORK	OUT-OF-NETWORK
NEW: For the following services, you do not need to meet your deductible first. These costs do not apply to your annual out-of-pocket coinsurance maximum. There is a separate co-pay out-of-pocket maximum for the following services.		
Preventive Care	No charge	\$50 co-pay
Well-Baby, Well-Child Visits	No charge	\$50 co-pay
Primary Care	\$30 co-pay	\$50 co-pay
Specialist Care	\$40 co-pay	\$65 co-pay
Mental Health and Substance Abuse [1] [2]	\$30 co-pay	\$50 co-pay
NEW: Out-of-Pocket Co-pay Maximum	\$1,100	none
For the following services, you do not need to meet your deductible first. These costs do not apply to your annual out-of-pocket coinsurance maximum.		
NEW: Convenience Clinics/Urgent Care Facilities	\$30 co-pay	
Emergency Room (waived if admitted)	\$100 co-pay	
X-ray, Lab and Diagnostics	100% covered after office co-pay	100% covered after office co-pay up to MAC
Chiropractic (medical necessity criteria may apply)	Visits 1-20: \$30 Visits 21 and up: \$40	Visits 1-20: \$50 Visits 21 and up: \$65
Pharmacy		
Annual Deductible	\$100 per member	
Pharmacy (30-day supply only from pharmacies in the 30-day network)	\$10 co-pay generic; \$40 co-pay preferred brand; \$90 co-pay non-preferred brand	Co-pay plus any amount exceeding MAC
Pharmacy (90-day supply only from special, less costly 90-day network or mail order)	\$20 co-pay generic; \$80 co-pay preferred brand; \$180 co-pay non-preferred brand	Co-pay plus any amount exceeding MAC
NEW: Pharmacy (90-day supply for certain medications only from special, less costly 90-day network or mail order) [3]	\$10 co-pay generic; \$40 co-pay preferred brand	Co-pay plus any amount exceeding MAC

For the following services, you must meet your deductible before the plan will begin to pay benefits. These costs apply to your annual out-of-pocket maximum.		
Inpatient Care (including mental health and substance abuse) [2]	25% coinsurance	50% coinsurance
Outpatient Surgery [2]	25% coinsurance	50% coinsurance
Ambulance (air and ground)	25% coinsurance	
Advanced X-ray, Scans and Imaging [2]	25% coinsurance	50% coinsurance
OT/PT/Speech Therapy	25% coinsurance	50% coinsurance
Deductible		
Employee Only	\$750	\$1,500
NEW: Employee + Child(ren)	\$1,250	\$2,500
Employee + Spouse	\$1,500	\$3,000
Employee + Spouse + Child(ren)	\$2,000	\$4,000
Out-of-Pocket Maximum		
Employee Only	\$6,000	\$12,000
NEW: Employee + Child(ren)	\$10,000	\$20,000
Employee + Spouse	\$12,000	\$24,000
Employee + Spouse + Child(ren)	\$16,000	\$32,000

MAC stands for “maximum allowable charge.” The MAC is the most that a plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay the difference between the MAC and the actual charge.

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