2017 Benefit Plans Summary

	PPO1		PPO2		PPO3	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Primary doctor office visit	100% after $20 copay	80% after deductible	100% after $20 copay	60% after deductible	100% after $20 copay	60% after deductible
Teledoc	100% after $20 copay	Not covered	100% after $20 copay	Not covered	100% after $20 copay	Not covered
Specialist office visit	100% after $40 copay	80% after deductible	100% after $40 copay	60% after deductible	100% after $40 copay	60% after deductible
Preventive care	Covered at 100% (in-network only)					
Lifetime maximum	Unlimited					
Deductible Individual Family	$3,000 $6,000	$6,000 $12,000	$1,150 $2,300	$2,300 $4,600	$650 $1,300	$1,300 $2,600
Coinsurance (after you meet deductible)	You pay 0% Plan pays 100%	You pay 20% Plan pays 80%	You pay 20% Plan pays 80%	You pay 40% Plan pays 60%	You pay 20% Plan pays 80%	You pay 40% Plan pays 60%
Out-of-pocket maximums Individual Family	$3,250 $6,500	$12,000 $24,000	$2,600 $5,700	$4,500 $9,600	$2,100 $4,600	$3,500 $7,800
Annual company contribution to your Health Reimbursement Account (HRA)	$500 Individual $1,000 Family		NA		NA	
Emergency Services						
Emergency Room Services	100% after in-network deductible plus $100 copay/visit (copay waived if admitted)		80% after in-network deductible plus $100 copay/visit (copay waived if admitted)		80% after in-network deductible plus $100 copay/visit (copay waived if admitted)	
Ambulance	100% after deductible		80% after deductible		80% after deductible	
Hospital Services						
Inpatient/Outpatient	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Maternity Services	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Most other medical services	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Mental Health and Substance Abuse						
Inpatient	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient	100% after $40 copay	80% after deductible	100% after $40 copay	60% after deductible	100% after $40 copay	60% after deductible
Therapy and Rehabilitation Services						
Physical Medicine	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Speech Therapy	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Spinal Manipulations (limit: 25 visits/calendar year)	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible

	PPO1		PPO2		PPO3	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Diagnostic Services						
Advanced Imaging (MRI, CAT Scan, PET scan)	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, lab/pathology, allergy testing)	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable medical equipment	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Transplant Services	100% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	Not covered
Infertility Counseling, Testing and Treatment	100% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not covered		Not covered		80% after deductible	60% after deductible
					6 attempts lifetime limit	

<u>To check doctors and hospitals in the network</u>

For coverage through Aetna: **www.aetna.com Aetna Choice POS II (Open Access) plan**

For coverage through Highmark Blue Cross Blue Shield: **www.highmarkbcbs.com BCBS PPO plan**

Prescription Drugs (Express Scripts)		
	In-network	**Out-of-network**
Retail (30 day supply)	**You pay cost of Rx up to:**	
Generic	$10 copay	Not covered
Formulary brand	$25 copay	Not covered
Non-formulary brand	$55 copay	Not covered
Mail order (90 day supply)		
Generic	$20 copay	Not covered
Formulary brand	$50 copay	Not covered
Non-formulary brand	$110 copay	Not covered
Out of pocket maximums Individual Family	 $1,000 $2,000	Not applicable

To check the prescription formulary:

www.express-scripts.com/DCSG