

2018 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	60% 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	60% 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	\$3,200	\$6,000	\$1,350	\$2,300	\$850	\$1,300
Family	\$6,400	\$12,000	\$2,700	\$4,600	\$1,700	\$2,600
Coinsurance (after you meet deductible)	You pay 20% Plan pays 80%	You pay 40% Plan pays 60%	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	\$3,750	\$12,000	\$2,800	\$4,500	\$2,300	\$3,500
Family	\$7,500	\$24,000	\$6,100	\$9,600	\$5,000	\$7,800
Annual company contribution to your Health Reimbursement Account (HRA)	\$500* Individual \$1,000* Family *prorated for newly enrolled		NA		NA	
Emergency Services						
Emergency Room Services	80% after in-network deductible plus \$150 copay/visit (copay waived if admitted)		80% after in-network deductible plus \$150 copay/visit (copay waived if admitted)		80% after in-network deductible plus \$150 copay/visit (copay waived if admitted)	
Ambulance	80% after deductible		80% after deductible		80% after deductible	
Hospital Services						
Inpatient/Outpatient	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Maternity Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Most other medical services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Mental Health and Substance Abuse						
Inpatient	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Office Visit	100% after \$20 copay	60% after deductible	100% after \$20 copay	60% after deductible	100% after \$20 copay	60% after deductible
Outpatient	80% after deductible	60% after deductible	100% after \$40 copay	60% after deductible	100% after \$40 copay	60% after deductible
Therapy and Rehabilitation Services						
Physical Medicine	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Speech Therapy	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Spinal Manipulations (limit: 25 visits/calendar year)	80% after deductible	60% 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)	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, lab/pathology, allergy testing)	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable medical equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Transplant Services	80% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	Not covered
Infertility Counseling, Testing and Treatment	80% after deductible	60% 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	

To check doctors and hospitals in the network

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	\$30 copay	Not covered
Non-formulary brand	\$65 copay	Not covered
Mail order (90 day supply)		
Generic	\$20 copay	Not covered
Formulary brand	\$60 copay	Not covered
Non-formulary brand	\$130 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