

Plans Effective: 01/01/12

POS250D	
IN NETWORK	
Annual Deductible & Coinsurance	
Annual Deductible:	\$1,000 / \$2,000 *out of network \$2,000/\$4,000
Out of Pocket Maximum:	\$5,000/\$10,000 *out of network \$10,000 / \$20,000
Coinsurance:	20% *out of network 50%
Annual Maximum Benefit:	Unlimited
Lifetime Maximum Benefit:	Unlimited
Office Visits	
Primary Care Phys. Age 0 - 18	\$25
Primary Care Phys. Age 19+	\$25
Specialist	\$40
Women's Services	
Maternity Inpatient	Covered in full after copay for initial visit
Routine GYN Visits	Covered in Full
Mammogram - Routine	Covered in Full
Inpatient Hospital Care	
Semi-private room	after deductible you pay 20%
Outpatient Surgery	
Hospital / Ambulatory Facility	you pay 20%
Diagnostic Services	
Laboratory	you pay 20%
X-Rays	you pay 20%
Emergency Care	
Emergency room visit	after deductible you pay 20%
Emergency ambulance	after deductible you pay 20%
After Hours Care Center	you pay 20%
Mental Health Care	
Inpatient	after deductible you pay 20%
Outpatient	you pay 20%
Substance Abuse Treatment	
Inpatient (detoxification only)	after deductible you pay 20%
Outpatient treatment	\$40
Other Services	
Chiropractic care	\$40
Durable Medical Equipment	you pay 50%
Skilled nursing facility (non cust.)	after deductible you pay 20%
Home Care Services	\$25
Dependent Coverage	26/26
Prescription Drugs	\$15/\$50/50%
Mail Order	2.5 copays per 90 day supply
Monthly Rates	
Group	
Single:	\$324.50
Family:	\$858.51
Sole Prop	
Single:	\$324.50
Family:	\$858.51

POS 8100	
HSA Qualified - High Ded.	
current 7100 members will auto roll to this new plan	
Annual Deductible:	\$1,500/\$3,000 *out of network \$1,500/\$3,000
Out of Pocket Maximum:	\$5,000/\$10,000 *out of network \$10,000 / \$20,000
Coinsurance:	20% *out of network 40%
Annual Maximum Benefit:	Unlimited
Lifetime Maximum Benefit:	Unlimited
IN NETWORK	
Primary Care Phys. Age 0 - 18	after deductible you pay 20% (0 well child)
Primary Care Phys. Age 19+	after deductible you pay 20%
Specialist	after deductible you pay 20%
Women's Services	
Maternity Inpatient	after deductible you pay 20%
Routine GYN Visits	Covered in Full
Mammogram - Routine	Covered in Full
Inpatient Hospital Care	
Semi-private room	after deductible you pay 20%
Outpatient Surgery	
Hospital / Ambulatory Facility	after deductible you pay 20%
Diagnostic Services	
Laboratory	after deductible you pay 20%
X-Rays	after deductible you pay 20%
Emergency Care	
Emergency room visit	after deductible you pay 20%
Emergency ambulance	after deductible you pay 20%
After Hours Care Center	after deductible you pay 20%
Mental Health Care	
Inpatient	after deductible you pay 20%
Outpatient	after deductible you pay 20%
Substance Abuse Treatment	
Inpatient (detoxification only)	after deductible you pay 20%
Outpatient treatment	after deductible you pay 20%
Other Services	
Chiropractic care	after deductible you pay 20%
Durable Medical Equipment	after deductible you pay 20%
Skilled nursing facility (non cust.)	after deductible you pay 20%
Home Care Services	after deductible you pay 20%
Dependent Coverage	26/26
Prescription Drugs	\$15/\$50/50% after deductible
Mail Order	2.5 copays per 90 day supply
Monthly Rates	
Group	
Single:	\$256.80
Family:	\$659.63
Sole Prop	
Single:	\$256.80
Family:	\$659.63

NOTE: This summary compares certain benefit components of the featured plans and it is to be used for general comparison purposes only. Inadvertent discrepancies may occur between this

This document was created with Win2PDF available at <http://www.win2pdf.com>.
The unregistered version of Win2PDF is for evaluation or non-commercial use only.
This page will not be added after purchasing Win2PDF.