2017 HDHP Gold Plan		
	In-Network **You Pay**	**Out-of-Network** **You Pay**
Annual Deductible	$1,500 Employee Only Coverage $3,000 Employee & Spouse/Domestic Partner, Employee & Child(ren) and Family Coverage *Deductible is non-embedded for Employee & Spouse/ Domestic Parner, Employee & Child(ren) and Family Coverage.*	$3,000 Employee Only Coverage $6,000 Employee & Spouse/Domestic Partner, Employee & Child(ren) and Family Coverage *Deductible is non-embedded for Employee & Spouse/ Domestic Parner, Employee & Child(ren) and Family Coverage.*
Coinsurance	10%	30%
Annual Out-of-Pocket (OOP) Maximum - Includes the Annual Deductible	$4,000 Employee Only Coverage $8,000 Employee & Spouse/Domestic Partner, Employee & Child(ren) and Family Coverage *Out-of-pocket maximum is embedded for Employee & Spouse/Domestic Parner, Employee & Child(ren) and Family Coverage.*	$8,000 Employee Only Coverage $16,000 Employee & Spouse/Domestic Partner, Employee & Child(ren) and Family Coverage *Out-of-pocket maximum is embedded for Employee & Spouse/Domestic Parner, Employee & Child(ren) and Family Coverage.*
Lifetime Maximum	None	None
Acupuncture	10% after deductible	30% after deductible
Combined In- and Out-of-Network maximum benefit of 20 visits.		
Allergy Including injections	10% after deductible	30% after deductible
Ambulance Medically necessary only	10% after deductible (Emergency) 50% after deductible (Non Emergency)	10% after in-network deductible (Emergency) 50% after in-network deductible (Non Emergency)
Chiropractic Care	10% after deductible	30% after deductible
Combined In- and Out-of-Network maximum benefit of $1,500 per year.		
Doctor/Specialist/ Surgeon Services – Office Visit – In-Hospital Visit – Surgery In and Outside Doctor's Office	10% after deductible	30% after deductible
Durable Medical Equipment	10% after deductible	30% after deductible

Emergency Room Services	10% after deductible	10% after in-network deductible
Hearing Aid/ Hearing Aid Exam	10% after deductible	30% after deductible
	Combined In- and Out-of-Network maximum benefit of $1,000 per hearing aid per ear; every 5 years.	
Home Health Services, including Visiting Nurse & Aide	10% after deductible	30% after deductible
	Combined In- and Out-of-Network maximum benefit of 100 visits per year.	
Hospital Inpatient	10% after deductible	30% after deductible
Infertility – Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only. Coverage is not available for dependent children.	10% after deductible	30% after deductible
	Benefits for infertility services are limited to $25,000 per covered member during the entire period you are covered under the Plan. There is a separate infertility prescription drug benefit limited to $10,000 per covered member during the entire period you are covered under the Plan. **Please contact your medical plan vendor prior to receiving infertility services, as there are certain requirements you must follow in order for infertility services and supplies to be considered covered health services under the Plan.**	
Maternity – Prenatal care – Delivery, routine nursery care & pediatric visits in hospital	10% after deductible	30% after deductible
Mental Health/ Substance Abuse – Outpatient Includes Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders	10% after deductible	30% after deductible
Outpatient Surgery Facility Charge – Hospital or Ambulatory Surgical Center	10% after deductible	30% after deductible
Physical/ Occupational Therapy	10% after deductible	30% after deductible
	Combined In- and Out-of-Network maximum benefit of 30 visits per year for combined occupational & physical therapy.	

Prescription Drugs	**Administered through Express Scripts, Inc. (ESI)** **<u>Non-Preventive Medications</u>** <u>Retail</u>: up to 30-day supply *Generic:* You pay the full cost of the prescription drug until you meet the deductible, then a $10 copay *Brand Name (preferred):* You pay the full cost of the prescription drug until you meet the deductible, then 25% of the cost of the prescription drug; $35 minimum, $75 maximum *Brand Name (Non-Preferred):* You pay the full cost of the prescription drug until you meet the deductible, then 35% of the cost of the prescription drug; $60 minimum, $150 maximum <u>Mail Order*</u>: 90-day supply *Generic/Brand Name (Preferred)/Brand Name (Non-Preferred):* You pay the full cost of the prescription drug until you meet the deductible, then 2.5 times the cost of the prescription drug at a retail pharmacy; minimums and maximums apply for brand name drugs. **<u>Preventive Medications</u>** <u>Retail</u>: up to 30-day supply *Generic:* $0 copay; deductible does not apply *Brand Name (preferred):* $10 copay; deductible does not apply *Brand Name (Non-Preferred):* $25 copay; deductible does not apply <u>Mail Order*</u>: 90-day supply *Generic:* $0 copay; deductible does not apply *Brand Name (Preferred)/Brand Name (Non-Preferred):* 2.5 times the cost of the prescription drug at a retail pharmacy; deductible does not apply * After the third refill of a maintenance medication at a retail pharmacy, you will be required to fill your medication through mail order. Failure to opt into the program will result in you paying 100% of the discounted cost of your maintenance medication.	Not Covered

Preventive Care – Well Child and Adult	0%	30% after deductible
Prosthetics	10% after deductible	30% after deductible
Radiation Therapy/ Chemotherapy	10% after deductible	30% after deductible
Radiologist, Anesthesiologist & Pathologist Inpatient Hospital	10% after deductible *Including services performed by a non-participating provider in a network hospital/ ambulatory surgery center*	30% after deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility	10% after deductible	30% after deductible
	Combined In- and Out-of-Network maximum benefit of 90 days per year.	
Speech Therapy Includes services for developmental delays limited to age 5	10% after deductible	30% after deductible
	Combined In- and Out-of-Network maximum benefit of 30 visits per year.	
Urgent Care Facility	10% after deductible	30% after deductible
X-Ray & Laboratory Preventive	0%	30% after deductible
X-Ray & Laboratory Non Preventive	10% after deductible	30% after deductible
Notification/ Pre-certification	Certain services require notification to carrier. They include: – All in/out-of-network hospital stays – Dental (accident only) – Home Health Care – Hospice Care – Reconstructive procedures – Skilled Nursing/Inpatient Rehab Facility confinement – Maternity (inpatient stays greater than 48/96 hours) – Transplant services *Non-compliance reduces benefit amount that would have been paid by $500 per occurrence. Penalty is not considered for deductible/coinsurance/out-of-pocket maximum.*	