



Schedule of Benefits...

Specially Designed for Electrolock, Inc.
Effective January 1, 2014

	In-Network	Out-of-Network
Calendar Year Deductible <i>Amount Employee pays before coshare percentages</i>	Single: \$0.00 Family: \$0.00	Single: \$3,000 Family: \$6,000
Coshare Percentage <i>Coshare max doubles per family</i>	0% FOR BALANCE OF YEAR	30% of 1st \$10,000 THEN 0% FOR BALANCE OF YEAR
Hospital Charges Inpatient/Outpatient	0% Plan Coshare	30% Plan Coshare AFTER \$200 PER OCCURRENCE DED.
Emergency Room Charge <i>Copay is waived if immediately admitted to the hospital</i>	\$150 Per Visit Copay	\$150 Per Visit Copay
Sickness/Injury – Physician Charges – Office Visit	0% Plan Coshare \$25 Per Visit Copay	30% of Target Prices 30% of Target Prices
WellCare – Physician Charges – Office Visit	0% Plan Coshare Deductible Waived	30% of Target Prices 30% of Target Prices
Other Covered Expenses <i>Coshare Example: Supplies, lab & X-ray, Durable Medical Equipment, Injections, etc</i>	0% Plan Coshare	30% of Target Prices
Retail Prescription Drug – 30 Day Supply	\$10/GENERIC \$35/PREFERRED \$55/NON PREFERRED	40% Plan Coshare All Deductibles Apply
Mail-Order Prescription Drug – 90 Day Supply	\$25.00/GENERIC \$87.50/PREFERRED \$137.50/NON PREFERRED	N/A
Care Advocacy Pathway (CAP) <i>Care Advocacy Pathway is often referred to as Chronic Care or Disease Management</i>	0% Plan Coshare DEDUCTIBLE WAIVED	0% Plan Coshare DEDUCTIBLE WAIVED

*** This is a summary in outline form of the Benefits. Eligible persons who choose to participate should review the SUMMARY PLAN DESCRIPTION and PLAN DOCUMENT (Benefit Booklet) for information about; participation, benefits, limitations, and exclusions. This is not a contract, policy or guarantee of coverage.***



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Other Coverage Notes:

- Second Surgical Opinion requested by BAC, Hospice, Centers of Excellence, and Pre-Admission Testing recommended by BAC, and Optional Benefits are paid by the Plan at 100% (0% member out of pocket) of covered expenses.
- Deductible waived for Maternity Care (if treatment begins within 1st trimester).
- Lifetime Maximum for Temporomandibular Joint Dysfunction Syndrome (TMJ) is \$1,500.
- Chiropractic Services limited to a maximum benefit of \$500 per year. Office visit copay applies.
- When a brand name drug is purchased when a generic is available, the member will pay the generic copay plus the difference in cost between the brand and the generic. If the doctor writes the prescription as "Dispense as Written", the standard copays will apply.
- Specialty medications are subject to a 25% copay, with a maximum copay of \$500/script and an annual maximum copay of \$2,500. Specialty medications are limited to a 30 day supply whether they are retail or home delivery.

Target Prices – are used as the maximum allowable payment for out-of-network (non-participating) providers. The Target Price fee schedule applies to provider procedure codes (called CPT-4's or DRG's) and will cover most charges made by a Provider. The Target fee schedule is 115% of the Medicare reimbursement rate, which means that reimbursement is set at 15% more under this Plan than is paid for providing the same service to a Medicare patient. Any provider charge in excess of the Target Price will not be a covered expense under the terms of this Plan and will be the responsibility of the Covered Person.

If you choose to see an out-of-network Provider, you should ask prior to treatment if he or she will accept Target Price (115% of the Medicare reimbursement) as payment-in-full. If the Provider agrees you will not be responsible for any excess charge. Therefore, it is important that you obtain written verification. If not, you will be responsible for paying the balance of the charges.



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Benefits Based on Usual and Customary

Dental coverage is available at any licensed dentist; there is no network selection required.

	Dental Plan
Plan Year Deductible <i>Employee pays before coshare percentages</i>	\$0.00 Per Person / \$0.00 Per Family
Type I – Preventive/Diagnostic: <i>Flouride Treatments, X-rays, Cleanings, Periodic Exams</i>	No Deductible 0% CoShare
Type II – Basic Restorative: <i>Extractions, Fillings, Oral Surgery, Root Canals</i>	No Deductible 10% CoShare
Type III – Major Restorative: <i>Bridges, Crowns, Dentures, Partial</i>	No Deductible 40% CoShare
Maximum Benefit Paid Per Year: <i>For Type I, II, III Services</i>	Unlimited
Type IV – Orthodontia: <i>applies to covered dependents under age 19</i>	40% Plan Coshare
Type IV – Orthodontia Lifetime Maximum	Unlimited

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Complete Eye Exam <i>Per Covered Individual</i>	\$10.00 Copay
Single Vision <i>Per Pair</i>	\$10.00 Copay
Bifocal <i>Per Pair</i>	\$10.00 Copay
Trifocal <i>Per Pair</i>	\$10.00 Copay
Sphere <i>Each diopter over + 4</i>	\$10.00 Copay
Cylinder <i>Each diopter over + 3</i>	\$10.00 Copay
Frames <i>Per Covered Individual</i>	\$25.00 Copay
Frame Maximum <i>Per Covered Individual</i>	\$120.00 - One every 24 months
Contact Lens <i>Per Covered Individual</i>	\$10.00 Copay
Contact Lenses Maximum <i>Per Pair</i>	\$150.00 - One every year

Benefits are available for either contact lenses or glasses (one or the other, but not both) once every 24 months.

Lens Options covered at 50% of the retail cost: Standard Progressive & Premium Progressive plastic; Solid Tints & Dyes; Plastic Gradient Dye; UV Protection; Scratch Resistant Coating; Anti-Reflective Coating; Photochromic Lenses Plastic

**Benefits based on Calendar Year.*