



# Schedule of Benefits...

**Specially Designed for Thomas 5 LTD**  
**Effective October 1, 2013**

	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Calendar Year Deductible</b> <i>Amount Employee pays before coshare percentages</i>	Single: \$1,000 ..... Family: \$2,000	Single: \$4,000 ..... Family: \$8,000
<b>Coshare Percentage</b> <i>Coshare max doubles per family</i>	30% of 1st \$6,666 THEN 0% FOR BALANCE OF YEAR	40% of 1st \$22,500 THEN 0% FOR BALANCE OF YEAR
<b>Hospital Charges</b> Inpatient/Outpatient	30% Plan Coshare	40% of Target Prices
<b>Emergency Room Charge</b> <i>Copay is waived if immediately admitted to the hospital</i>	30% Plan Coshare \$300 Per Visit Copay	30% of Target Prices \$300 Per Visit Copay
<b>Sickness/Injury – Physician Charges</b> – Office Visit	30% Plan Coshare ..... \$30 Per Visit Copay	40% of Target Prices ..... 40% of Target Prices
<b>WellCare – Physician Charges</b> – Office Visit	0% Plan Coshare ..... Deductible Waived	40% of Target Prices ..... 40% of Target Prices
<b>Other Covered Expenses</b> <i>Coshare Example: Supplies, lab &amp; X-ray, Durable Medical Equipment, Injections, etc</i>	30% Plan Coshare	40% of Target Prices
<b>Retail Prescription Drug</b> – 30 Day Supply	\$15/GENERIC \$35/PREFERRED \$60/NON PREFERRED	40% Plan Coshare All Deductibles Apply
<b>Mail-Order Prescription Drug</b> – 90 Day Supply	\$37.50/GENERIC \$87.50/PREFERRED \$150/NON PREFERRED	N/A
<b>Care Advocacy Pathway (CAP)</b> <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%.
- Annual Maximum for all Benefits paid under this plan is \$2,500,000.
- Deductible waived for Maternity Care (if treatment begins within 1st trimester).
- Chiropractic Services limited to a maximum benefit of 12 visits per year. Office visit copay applies.
- Annual Maximum for Temporomandibular Joint Dysfunction Syndrome (TMJ) is \$1,500.
- In-Network providers participate in the Cigna (PPO) Provider Network.

**Target Prices (Plan A)** – 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
<b>Plan Year Deductible</b> <i>Employee pays before coshare percentages</i>	\$50 Per Person / \$150 Per Family
<b>Type I – Preventive/Diagnostic:</b> <i>Flouride Treatments, X-rays, Cleanings, Periodic Exams</i>	No Deductible 0% CoShare
<b>Type II – Basic Restorative:</b> <i>Extractions, Fillings, Oral Surgery, Root Canals</i>	Deductible Applies 20% CoShare
<b>Type III – Major Restorative:</b> <i>Bridges, Crowns, Dentures, Partial</i>	Deductible Applies 50% CoShare
<b>Maximum Benefit Paid Per Year:</b> <i>For Type I, II, III Services</i>	\$1,500.00
<b>Type IV – Orthodontia:</b> <i>applies to covered dependents under age 19</i>	50% Plan Coshare
<b>Type IV – Orthodontia Lifetime Maximum</b>	\$1,500.00

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**Specially Designed for Thomas 5 LTD – VISION CARE**

<b>Complete Eye Exam</b> <i>Per Covered Individual</i>	<b>\$10.00 Copay - One every 12 months</b>
<b>Single Vision</b> <i>Per Pair</i>	<b>\$25.00 Copay - One every 24 months</b>
<b>Bifocal</b> <i>Per Pair</i>	<b>\$25.00 Copay - One every 24 months</b>
<b>Trifocal</b> <i>Per Pair</i>	<b>\$25.00 Copay - One every 24 months</b>
<b>Sphere</b> <i>Each diopter over + 4</i>	<b>\$25.00 Copay - One every 24 months</b>
<b>Cylinder</b> <i>Each diopter over + 3</i>	<b>\$25.00 Copay - One every 24 months</b>
<b>Frame Maximum</b> <i>Per Covered Individual</i>	<b>\$130.00 - One every 24 months</b>
<b>Contact Lenses Maximum</b> <i>Per Pair</i>	<b>\$130.00 - One every 24 months</b>

Lens tinting, initialing and sunglasses are not eligible expenses. Benefits are available for either contact lenses or glasses (one or the other, but not both) once every 24 months.

*\*Benefits based on Calendar Year.*