



Benefit Summary:

Effective Date: For plans effective on or after 1/1/16

	2016 Silver POS 8100		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	100		
Deductible	\$2,000 single / \$4,000 family	\$2,000 single / \$4,000 family	True Family - On family plans, any individual can incur up to the family deductible amount.
First Dollar Coverage	N/A	Not Covered	
Coinsurance	20% after deductible	40% after deductible	
Out of Pocket Maximum	\$5,000 single / \$10,000 family	\$10,000 single / \$20,000 family	Embedded Out of Pocket Maximum - On family plans, one person cannot exceed the individual out of pocket maximum amount.
Deductible and Out of Pocket Administration Type	True Family Deductible and Embedded Out of Pocket	True Family Deductible and Embedded Out of Pocket	
Benefit Administration	Plan year	Plan year	
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy and Sigmoidoscopy Contraceptive drugs, Devices and Counseling Immunizations Mammogram Pap smear Prostate test (Prostate Specific Antigen "PSA") Routine physical exam Prenatal and one postpartum visit Well child visit Well woman visit	Covered In Full	40% coinsurance after Deductible	Some routine services may not be covered Out-of-Network. Please contact Customer Service.
Physician and Other Services			
Primary Office Visit	20% coinsurance after deductible	40% coinsurance after Deductible	
Specialist Office Visit	20% coinsurance after deductible	40% coinsurance after Deductible	
Allergy Testing and Treatment	20% coinsurance after deductible	40% coinsurance after Deductible	



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Physician and Other Services			
Outpatient Surgical Procedures (in physician's office)	20% coinsurance after deductible	40% coinsurance after Deductible	
Emergency and Urgent Care Services			
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	Cost-share waived if admitted.
Ambulance	20% coinsurance after deductible	20% coinsurance after deductible	
Urgent Care	20% coinsurance after deductible	20% coinsurance after Deductible	
Hospital Services			
Inpatient Hospital	\$750 copay after deductible per admission	40% coinsurance after Deductible	
Outpatient Surgical Procedures (facility)	20% coinsurance after deductible	40% coinsurance after Deductible	
Skilled Nursing Facility	\$750 copay after deductible per admission	40% coinsurance after Deductible	Unlimited days per plan year
Diagnostic Testing Services			
Laboratory Testing	20% coinsurance after deductible	40% coinsurance after Deductible	
Radiology	20% coinsurance after deductible	40% coinsurance after Deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care	20% coinsurance after deductible	40% coinsurance after Deductible	
Inpatient Maternity	\$750 copay after deductible per admission	40% coinsurance after Deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	\$750 copay after deductible per admission	40% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Outpatient Mental Health	20% coinsurance after deductible	40% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Rehab	\$750 copay after deductible per admission	40% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Detox	\$750 copay after deductible per admission	40% coinsurance after Deductible	Unlimited visits, subject to medical necessity



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Mental Health and Substance Abuse			
Outpatient Substance Abuse	20% coinsurance after deductible	40% coinsurance after Deductible	Unlimited visits, up to 20 visits a year may be used for family counseling; subject to medical necessity.
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	20% coinsurance after deductible	40% coinsurance after Deductible	Diabetic equipment rendered at pharmacy will be covered as a medical benefit.
Insulin and Other Oral Agents	20% coinsurance after deductible	40% coinsurance after Deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	20% coinsurance after deductible	40% coinsurance after Deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Rehabilitation Services			
Chiropractic Care	20% coinsurance after deductible	40% coinsurance after Deductible	
Physical - Occupational - Speech Therapies	20% coinsurance after deductible	40% coinsurance after Deductible	60 combined rehabilitative PT/OT/ST visits per person, per plan year.
Pulmonary Rehabilitation	20% coinsurance after deductible	40% coinsurance after Deductible	
Additional Services			
Durable Medical Equipment	20% coinsurance after deductible	40% coinsurance after Deductible	
Prosthetics and Appliances	20% coinsurance after deductible	40% coinsurance after Deductible	
Chemotherapy - Outpatient Facility	20% coinsurance after deductible	40% coinsurance after Deductible	
Hospice	20% coinsurance after deductible	40% coinsurance after Deductible	210 days per plan year
Home Health Care	20% coinsurance after deductible	40% coinsurance after Deductible	40 aggregate visits per plan year; includes home infusion.



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Additional Services			
Wellness Card	\$250 per contract	N/A	Benefit allowance accessible through use of debit card at participating providers for gym membership, massage, acupuncture, health food stores, chiropractic visits, etc.
Prescription Drug Coverage			
Prescription Drug	\$5/\$30/50% after deductible	Not Covered	
Mail Order	2.5 copay - 90 day supply after deductible	Not Covered	
Medicare Part D Creditable Coverage Status	Yes	N/A	
Pediatric Vision Services			
Routine Exam	20% coinsurance after deductible	Not Covered	One routine eye exam covered in full every other year
Medical Eye Exam	20% coinsurance after deductible	40% coinsurance after Deductible	
Standard Plastic Lenses, Frames and Conventional Contact Lenses	30% coinsurance after deductible	Not Covered	Cover standard frames/lenses OR contact lenses every 12 months
Adult Vision Services			
Routine Exam	20% coinsurance after deductible	Not Covered	One routine eye exam covered in full every other year
Medical Eye Exam	20% coinsurance after deductible	40% coinsurance after Deductible	
Standard Plastic Lenses	\$50 allowance	Not Covered	
Frames	40% off retail price	Not Covered	
Conventional Contact Lenses	15% off retail price	Not Covered	
Laser Vision Correction	15% off retail price or 5% off promotional price	Not Covered	
Dental Services			
*Pediatric Dental - see statement below	\$18.21 premium per child		
Dependent Coverage			
Dependent age	26	26	



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Dependent Coverage			
Domestic partner and children	Covered	Covered	

This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan.

*PEDIATRIC DENTAL IS AN ESSENTIAL HEALTH BENEFIT REQUIRED FOR DEPENDENTS UNDER AGE 19. COVERAGE WILL BE OFFERED TO YOUR EMPLOYEES, AND IF ELECTED, WILL APPEAR ON YOUR PREMIUM INVOICE. YOU WILL BE RESPONSIBLE TO COLLECT THE PREMIUM.