

2024 SMALL GROUP PLANS



dh Deaconess OneCare



SIHO NETWORK Plus



Community Health Direct



UNION HEALTH
AN INTEGRATED HEALTH PLAN



Good Samaritan
Direct Health



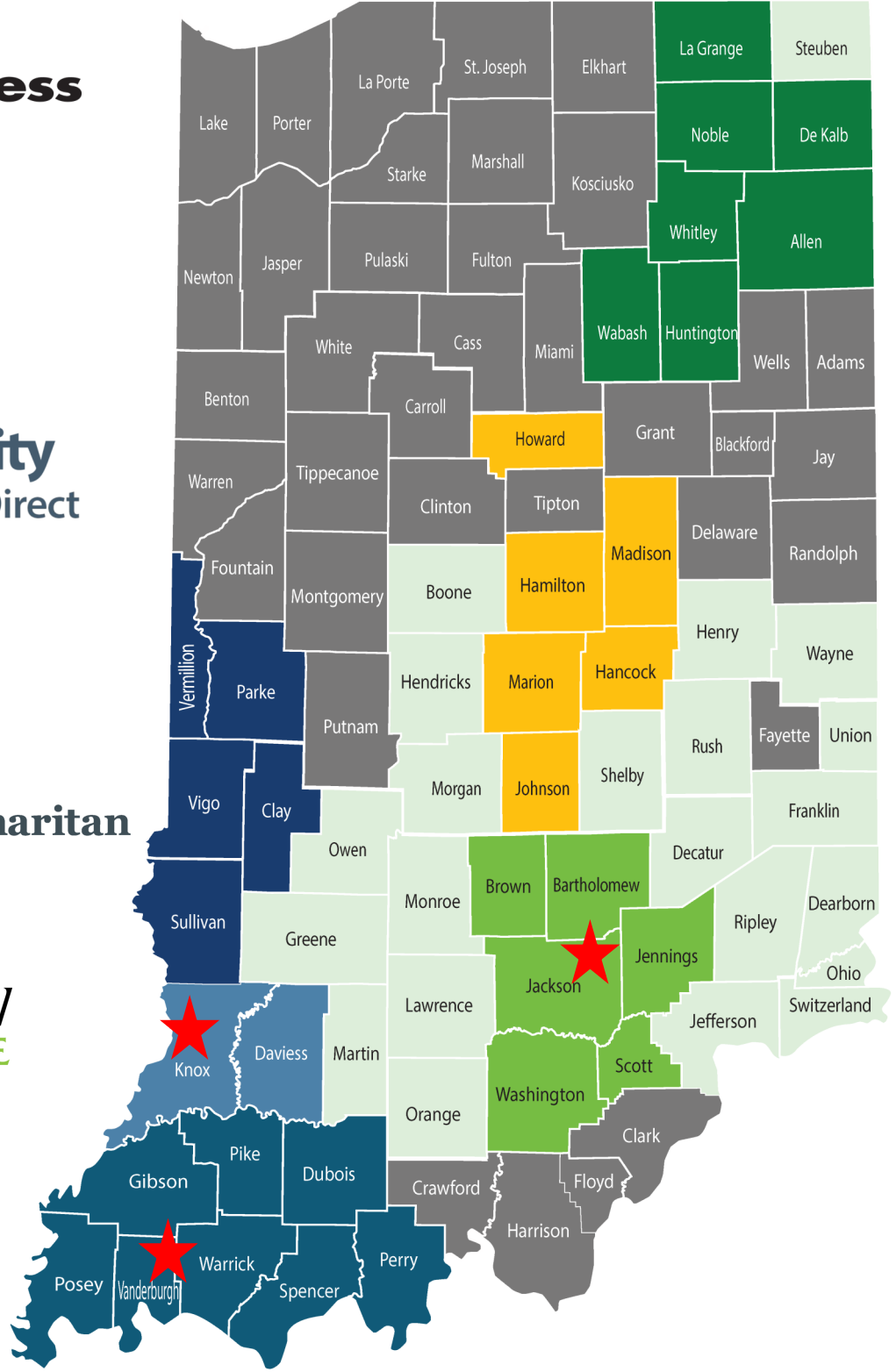
PARKVIEW SELECT CARE



encore COMBINED







Employer Clinic available







SIHO INSURANCE SERVICES






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CHOOSE YOUR NETWORK


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YOUR PLAN OPTIONS

Plan Type & Deductible	Deaconess OneCare 		SIHO Plus  		Community Health		Union Health- An Integrated Health Plan		Good Samaritan Direct Health  		Parkview Select Care		Encore Combined	
	2 Tier	3 Tier	2 Tier	3 Tier	2 Tier	3 Tier	2 Tier	3 Tier	2 Tier	3 Tier	2 Tier	3 Tier	2 Tier	3 Tier
PPO 1500	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
PPO 2500	✓		✓		✓						✓		✓	
PPO 3000		✓		✓		✓		✓		✓		✓		
PPO 4000	✓		✓		✓						✓			
PPO 5000		✓		✓		✓		✓		✓		✓		✓
PPO 6000	✓		✓		✓						✓		✓	
PPO 7000	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
PPO 4100													✓	
PPO 3000														✓
HSA 3200	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
HSA 5000	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
HSA 7000	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
HSA 8500													✓	

 = Employer Clinic Included (Clinic details included where applicable)

 = Chamber Endorsed Plan

PEDIATRIC DENTAL OPTION

The following benefits include the **Certified EHB Dental Benefits** covered by **Delta Dental of Indiana**



Pediatric Dental Plan (Dependents under age 19)

	Delta Dental Premier® Dentist	Delta Dental Premier® Dentist	Non Participating Dentist
	Plan Pays	Plan Pays	Plan Pays
Diagnostic & Preventive Services			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	90%	80%	80%
Emergency Palliative Treatment - to temporarily relieve pain	90%	80%	80%
Radiographs - X-Rays	90%	80%	80%
Sealants - to prevent decay of permanent teeth	90%	80%	80%
Basic Services			
Minor Restorative Services - fillings and crown repair	50%	50%	50%
Oral Surgery Services - extractions and dental surgery	50%	50%	50%
Endodontic Services - root canals	50%	50%	50%
Periodontics Services - to treat gum diseases	50%	50%	50%
Relines and Repairs - to bridges and dentures	50%	50%	50%
Other basic services - misc. services	50%	50%	50%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - bridges, dentures, and implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - Braces (when medically necessary)	50%	50%	50%
Orthodontic Age Limit	Up to age 19		
Plan Maximum	N/A		
Maximum out of Pocket: per person/per family/per calendar year. The Maximum applies for all EHB covered services provided by the PPO or Premier Dentist	\$350 / \$700		
Deductible - per person/ per family per calendar year. The deductible does not apply to exams, cleanings, fluoride, space maintainers, emergency palliative, treatment, sealants, and orthodontics.	\$50 / \$150		

VOLUNTARY DENTAL OPTIONS

Offered through Health Resources Inc. | HRI Network

Services	Paramount	Preferred	Standard	Value
Calendar Year Deductible	NONE	NONE	NONE	NONE
Plan Year Benefit	\$1,500	\$1,250	\$1,000	\$750
Lifetime Orthodontia Maximum	\$1,000	\$1,250	\$1,000	N/A
Preventive Services <ul style="list-style-type: none"> Oral Exam (once every 6 months) Routine Cleanings (once every 6 months) Fluoride Treatment for Children up to age 14 (once every 6 months) Space Maintainers for Children Topical Sealants for Children up to age 15 	100%	100%	100%	100%
Diagnostic Services <ul style="list-style-type: none"> Bitewing X-Rays (once every year) Full Mouth (one every 4 years) 	100%	100%	80%	60%
Diagnostic Services <ul style="list-style-type: none"> Amalgam, Silicate & Composite Fillings Simple Extractions Repairs of dentures, bridgework, and crowns Endodontic Therapy (Paramount and Preferred Plans only) 	80%	80%	60%	50%
Major Services <ul style="list-style-type: none"> Oral Surgery & Complex Extractions Periodontal Therapy Endodontic Therapy (Standard and Value Plans only) Full & Partial Dentures Implants as an Alternate Procedure (Covered at 50% on all plans) Crowns Bridges 	50%	80%	50%	50%
Orthodontia (for children under age 19)	50%	50%	50%	Not Covered
Employee Only:	\$33.29	\$34.15	\$29.04	\$26.29
Employee + Spouse:	\$69.91	\$71.73	\$60.96	\$55.20
Employee + Child(ren):	\$87.35	\$89.58	\$76.15	\$68.94
Employee + Family:	\$122.81	\$126.04	\$107.14	\$97.00

Minimum of 2 employees to offer.

For more information on the dental plan including OON benefits, please contact sales.quotes@siho.org.

PEDIATRIC VISION OPTION

PEDIATRIC VISION BENEFIT SUMMARY

Pediatric Vision is only provided to subscribers under age 19

Taking care of your child's eyes with VSP includes a covered-in-full benefit outlined below. You'll have access to the highest quality vision care from a VSP doctor you can trust.

Visit vsp.com/advantage to find a doctor who's right for your child and one who carries children's frames from our exclusive Otis & Piper™ Eyewear Collection.

VSP Doctor Network: VSP Advantage



Benefit	Description	Copay	Frequency
Your Coverage with a VSP Advantage Doctor			
WellVision Exam ®	A thorough eye exam that tests for childhood eye health and vision issues, like nearsightedness, amblyopia (lazy eye), and strabismus (crossed eyes)	\$0	Every 12 months
Prescription Glasses			
Frames	Frames from our exclusive Otis & Piper Eyewear Collection	\$0	Every 12 months
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, lined trifocal, or lenticular lenses Polycarbonate, scratch-resistant coating, and UV protection 	\$0 included in prescription glasses	Every 12 months
Lens Options	20% - 25% off other lens options	N/A	Every 12 months
Contacts (instead of glasses)			
	Contact lens exam and a minimum three-month's supply of contact lenses are covered in full. Ask your VSP doctor which contacts qualify for your child's plan.	\$0	Every 12 months

Extra Savings and Discounts	Glasses and Sunglasses 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam
	Laser Vision Correction Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change.

VOLUNTARY VISION OPTIONS

Offered through EyeMed Vision | Insight Network

Services	12/12 Plan	12/24 Plan
Eye Exam Frequency	Once every 12 Months	Once every 12 Months
Eye Exam Copay	\$10	\$10
Eyeglass Lens Frequency	Once every 12 Months	Once every 12 Months
Eyeglass Lens Copay	\$25 Additional charge for Progressive	\$25 Additional charge for Progressive
Eyeglass Frame Frequency	Once every 12 Months	Once every 24 Months
Eyeglass Frame Allowance	\$180 - 20% off balance over the \$180	\$150 - 20% off balance over the \$150
Eyeglass Frame Copay	\$0	\$0
Contact Lens Frequency	Once every 12 Months	Once every 12 Months
Contact Lens Allowance	\$180	\$150
Contact Lens Copay	\$0 - 15% off balance over the \$180	\$0 - 15% off balance over the \$150
Network	EyeMed	EyeMed
Employee Only:	\$9.62	\$6.30
Employee + Spouse:	\$18.28	\$11.97
Employee + Child(ren):	\$19.24	\$12.60
Employee + Family:	\$28.28	\$18.52



Minimum of 2 employees to offer.

For more information on the dental plan including OON benefits, please contact sales.quotes@siho.org.

Three Tier PPO



PPO \$1,500	Deaconess OneCare	Encore Combined	Out-of-Network
Plan Code: NLF / NNK			
Benefit Category			
Annual Single Deductible	\$1,500	\$3,000	\$6,000
Annual Family Deductible	\$3,000	\$6,000	\$12,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$5,000	\$7,500	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$10,000	\$15,000	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$60	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$60	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$60	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$3,000	Deaconess OneCare	Encore Combined	Out-of-Network
Plan Code: NLG / NNL			
Benefit Category			
Annual Single Deductible	\$3,000	\$6,000	\$12,000
Annual Family Deductible	\$6,000	\$12,000	\$24,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,000	\$8,700	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$12,000	\$17,400	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$55	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$55	\$110	Ded, 50%
Chiropractic (12 visits annual max)	\$55	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$5,000	Deaconess OneCare	Encore Combined	Out-of-Network
Plan Code: NLH / NNM			
Benefit Category			
Annual Single Deductible	\$5,000	\$8,150	\$16,300
Annual Family Deductible	\$10,000	\$16,300	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,100	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,200	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$7,000	Deaconess OneCare	Encore Combined	Out-of-Network
Plan Code: NLJ / NNN			
Benefit Category			
Annual Single Deductible	\$7,000	\$8,500	\$16,300
Annual Family Deductible	\$14,000	\$17,000	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,200	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,400	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$3,200 - Embedded	Deaconess OneCare	Encore Combined	Out-of-Network
Plan Code: NL4 / NN7			
Benefit Category			
Annual Single Deductible	\$3,200	\$5,800	\$11,200
Annual Family Deductible	\$6,400	\$11,600	\$22,400
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,000	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$14,000	\$15,000	\$42,300
PCP Office	Ded, \$25	Ded, \$55	Ded, 50%
Specialist Office	Ded, \$60	Ded, \$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625	Ded, \$625
Urgent Care	Ded, \$100	Ded, \$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$60	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$60	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, \$25	Ded, \$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$5,000 - Embedded	Deaconess OneCare	Encore Combined	Out-of-Network
Plan Code: NL5 / NN8			
Benefit Category			
Annual Single Deductible	\$5,000	\$6,500	\$13,800
Annual Family Deductible	\$10,000	\$13,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,500	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$13,000	\$15,000	\$42,300
PCP Office	Ded, 10%	Ded, 20%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 20%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, 10%	Ded, 20%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 20%	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$7,000 - Embedded	Deaconess OneCare	Encore Combined	Out-of-Network
Plan Code: NL6 / NN9			
Benefit Category			
Annual Single Deductible	\$7,000	\$7,500	\$13,800
Annual Family Deductible	\$14,000	\$15,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,500	\$8,000	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$15,000	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 20%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 20%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, 10%	Ded, 20%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 20%	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Two Tier PPO



PPO \$1,500	Deaconess OneCare	Out-of-Network
Plan Code: NLA / NNE		
Benefit Category		
Annual Single Deductible	\$1,500	\$6,000
Annual Family Deductible	\$3,000	\$12,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$5,000	\$27,300
Annual OOP max - family (inc ded, copay, coinsurance)	\$10,000	\$54,600
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

Disclaimer: This is a draft of product offerings. The intention of this document is to provide an overview of the plans and does not include plan exclusions and limitations.

Two Tier PPO



PPO \$2,500	Deaconess OneCare	Out-of-Network
Plan Code: NLB / NNF		
Benefit Category		
Annual Single Deductible	\$2,500	\$10,000
Annual Family Deductible	\$5,000	\$20,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$5,500	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$11,000	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$4,000	Deaconess OneCare	Out-of-Network
Plan Code: NLC / NNG		
Benefit Category		
Annual Single Deductible	\$4,000	\$16,000
Annual Family Deductible	\$8,000	\$32,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$6,000	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$12,000	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$40	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$40	Ded, 50%
Chiropractic (12 visits annual max)	\$40	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$6,000	Deaconess OneCare	Out-of-Network
Plan Code: NLD / NNH		
Benefit Category		
Annual Single Deductible	\$6,000	\$16,300
Annual Family Deductible	\$12,000	\$32,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,250	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,500	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$40	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$40	Ded, 50%
Chiropractic (12 visits annual max)	\$40	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$7,000	Deaconess OneCare	Out-of-Network
Plan Code: NLE / NNJ		
Benefit Category		
Annual Single Deductible	\$7,000	\$16,300
Annual Family Deductible	\$14,000	\$32,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$9,200	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$18,400	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$3,200 - Embedded	Deaconess OneCare	Out-of-Network
Plan Code: NL1 / NN2		
Benefit Category		
Annual Single Deductible	\$3,200	\$11,200
Annual Family Deductible	\$6,400	\$22,400
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,000	\$42,300
PCP Office	Ded, \$25	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, \$110	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, \$25	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$5,000 - Embedded	Deaconess OneCare	Out-of-Network
Plan Code: NL2 / NN5		
Benefit Category		
Annual Single Deductible	\$5,000	\$13,800
Annual Family Deductible	\$10,000	\$27,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,000	\$42,300
PCP Office	Ded, 10%	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, 10%	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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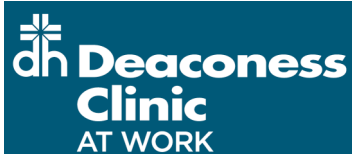
Two Tier HSA



HSA \$7,000 - Embedded	Deaconess OneCare	Out-of-Network
Plan Code: NL3 / NN6		
Benefit Category		
Annual Single Deductible	\$7,000	\$13,800
Annual Family Deductible	\$14,000	\$27,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$8,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, 10%	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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CLINIC INFORMATION



We're excited to announce that effective January 1, 2024 that Deaconess Clinic at Work is now automatically included within Deaconess OneCare Small and Large Group Plans at no additional cost.

Clinic is available to members in Gibson, Posey, Spencer, Vanderburgh, and Warrick counties.

In your program, you'll find the following benefits available to you and your dependents:



Free Provider Visits*

Sick Visits, Annual Exams, Sports & Wellness Physicals, Chronic Disease Management, Basic In-Office Procedures, Stitches, EKGs.



Free Medications

Find a list of these medications at deaconess.com/dcawformulary.



Free Labs

Find a list at deaconess.com/dcawformulary.



Free DC Video Visits

8am–8pm, 365 days a year (age 2 and older)



Free 24-Hour Nurse Line

*Due to IRS Regulations, members on a High Deductible Health Plan will be subject to a \$30 Office Visit Charge.

Visit your company's Deaconess Clinic at Work web page for access to:

- Appointment Scheduling
- Medication Refills
- DC LIVE
- And More!

Locations

Hours listed are as of January 1, 2024

First Avenue– 812-450-4066

309 N. 1st Ave.,
Evansville, IN
Mon: 8am–Noon
Tue: 1–5pm
Wed: 9am–1pm
Thu: 8am–Noon
Fri: Noon–4pm

Lynch Road– 812-450-8720

4949 Healthy Way,
Suite A, Evansville, IN
Mon: 1pm–5pm
Tue: 8am–Noon
Wed: 2pm–6pm
Thu: 1pm–5pm
Fri: 7am–11am
Sat: 8am–Noon

Ft. Branch– 812-615-5019

7898 S. Professional Dr.,
Ft. Branch, IN
Mon: 8am–2pm
Tue: 1–6pm
Thu: Noon–5pm
Fri: 7am–11am

Mt. Vernon– 812-490-0813

813 E. 4th St.,
Mt. Vernon, IN
Mon: 8am–5pm
Wed: Noon–6pm
Fri: 8am–2pm

Reo– 812-492-5940

3434 W. IN-66,
Reo, IN
Mon: 7:30am–9:30am & 1–5pm
Tue: 7:30am–Noon
Thu: Noon–5pm
Fri: 7:30am–Noon

Henderson– 270-215-3150

340 Starlite Dr.,
Henderson, KY
Mon: 9am–6pm
Wed: 8am–Noon
Fri: 7am–4pm

Owensboro– 270-561-0140

2710 Heartland Crossing Blvd.,
Owensboro, KY
Mon: 7am–3pm
Wed: 11am–5pm
Fri: 8am–2pm



Three Tier PPO



PPO \$1,500	SIHO Plus	Encore Combined	Out-of-Network
Plan Code: HDF			
Benefit Category			
Annual Single Deductible	\$1,500	\$3,000	\$6,000
Annual Family Deductible	\$3,000	\$6,000	\$12,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$5,000	\$7,500	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$10,000	\$15,000	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$60	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$60	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$60	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$3,000	SIHO Plus	Encore Combined	Out-of-Network
Plan Code: HDG			
Benefit Category			
Annual Single Deductible	\$3,000	\$6,000	\$12,000
Annual Family Deductible	\$6,000	\$12,000	\$24,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,000	\$8,700	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$12,000	\$17,400	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$55	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$55	\$110	Ded, 50%
Chiropractic (12 visits annual max)	\$55	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$5,000	SIHO Plus	Encore Combined	Out-of-Network
Plan Code: HDH			
Benefit Category			
Annual Single Deductible	\$5,000	\$8,150	\$16,300
Annual Family Deductible	\$10,000	\$16,300	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,100	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,200	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$7,000	SIHO Plus	Encore Combined	Out-of-Network
Plan Code: HDJ			
Benefit Category			
Annual Single Deductible	\$7,000	\$8,500	\$16,300
Annual Family Deductible	\$14,000	\$17,000	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,200	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,400	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$3,200 - Embedded	SIHO Plus	Encore Combined	Out-of-Network
Plan Code: HD4			
Benefit Category			
Annual Single Deductible	\$3,200	\$5,800	\$11,200
Annual Family Deductible	\$6,400	\$11,600	\$22,400
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,000	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$14,000	\$15,000	\$42,300
PCP Office	Ded, \$25	Ded, \$55	Ded, 50%
Specialist Office	Ded, \$60	Ded, \$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625	Ded, \$625
Urgent Care	Ded, \$100	Ded, \$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$60	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$60	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, \$25	Ded, \$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$5,000 - Embedded	SIHO Plus	Encore Combined	Out-of-Network
Plan Code: HD5			
Benefit Category			
Annual Single Deductible	\$5,000	\$6,500	\$13,800
Annual Family Deductible	\$10,000	\$13,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,500	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$13,000	\$15,000	\$42,300
PCP Office	Ded, 10%	Ded, 20%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 20%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, 10%	Ded, 20%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 20%	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$7,000 - Embedded	SIHO Plus	Encore Combined	Out-of-Network
Plan Code: HD6			
Benefit Category			
Annual Single Deductible	\$7,000	\$7,500	\$13,800
Annual Family Deductible	\$14,000	\$15,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,500	\$8,000	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$15,000	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 20%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 20%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, 10%	Ded, 20%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 20%	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Two Tier PPO



PPO \$1,500	SIHO Plus	Out-of-Network
Plan Code: HDA		
Benefit Category		
Annual Single Deductible	\$1,500	\$6,000
Annual Family Deductible	\$3,000	\$12,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$5,000	\$27,300
Annual OOP max - family (inc ded, copay, coinsurance)	\$10,000	\$54,600
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$2,500	SIHO Plus	Out-of-Network
Plan Code: HDB		
Benefit Category		
Annual Single Deductible	\$2,500	\$10,000
Annual Family Deductible	\$5,000	\$20,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$5,500	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$11,000	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$4,000	SIHO Plus	Out-of-Network
Plan Code: HDC		
Benefit Category		
Annual Single Deductible	\$4,000	\$16,000
Annual Family Deductible	\$8,000	\$32,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$6,000	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$12,000	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$40	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$40	Ded, 50%
Chiropractic (12 visits annual max)	\$40	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$6,000	SIHO Plus	Out-of-Network
Plan Code: HDD		
Benefit Category		
Annual Single Deductible	\$6,000	\$16,300
Annual Family Deductible	\$12,000	\$32,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,250	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,500	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$40	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$40	Ded, 50%
Chiropractic (12 visits annual max)	\$40	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$7,000	SIHO Plus	Out-of-Network
Plan Code: HDE		
Benefit Category		
Annual Single Deductible	\$7,000	\$16,300
Annual Family Deductible	\$14,000	\$32,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$9,200	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$18,400	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$3,200 - Embedded	SIHO Plus	Out-of-Network
Plan Code: HD1		
Benefit Category		
Annual Single Deductible	\$3,200	\$11,200
Annual Family Deductible	\$6,400	\$22,400
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,000	\$42,300
PCP Office	Ded, \$25	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, \$110	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, \$25	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$5,000 - Embedded	SIHO Plus	Out-of-Network
Plan Code: HD2		
Benefit Category		
Annual Single Deductible	\$5,000	\$13,800
Annual Family Deductible	\$10,000	\$27,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,000	\$42,300
PCP Office	Ded, 10%	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, 10%	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$7,000 - Embedded	SIHO Plus	Out-of-Network
Plan Code: HD3		
Benefit Category		
Annual Single Deductible	\$7,000	\$13,800
Annual Family Deductible	\$14,000	\$27,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$8,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, 10%	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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CLINIC INFORMATION



Plan members receive services at No Cost or Low Cost.

Clinic is available to Jackson, Jennings, Washington and Scott counties only.



Healthcare Services

- Treatment for minor medical problems (allergies, ear infections, flu, strep, minor infections and rashes, etc.)
- Respiratory conditions
- Digestive and urinary conditions
- Chronic disease management
- Blood pressure checks
- Annual physical exams
- On-site wellness coaching
- Health screenings
- Sports Physicals
- And More...



Prescriptions

Original prescriptions will be provided by WellLife. Refills of prescriptions can be filled with your local pharmacy or a mail-order pharmacy. Original prescriptions will be provided at no cost to most members. Members with high-deductible health plans will pay \$5.00 for prescriptions.*



Lab Work

Lab work ordered by WellLife will be drawn at the clinic. A list of labs available through the clinic is available. Labs ordered that are not available through WellLife will be processed through member's health plan. Labs will be provided at no cost to most members. Members with high-deductible health plans will pay \$15 per lab test performed at WellLife.*



High Deductible Health Plans

High-deductible health plans do not allow members to receive first-dollar coverage. To remain compliant & avoid tax penalties, it's necessary to charge a small fee for reasonable & customary services. Preventive services can be provided at no charge.

Hours:

Monday/Wednesday 8am–6pm
Tuesday/Thursday 7am–6pm
Friday 8am–4pm

Phone:

812-523-5185
Call to schedule
an appointment

Location:

100 North Walnut Street
Seymour, Indiana
47274

Three Tier PPO



PPO \$1,500	Community	Encore Combined	Out-of-Network
Plan Code: CMN			
Benefit Category			
Annual Single Deductible	\$1,500	\$3,000	\$6,000
Annual Family Deductible	\$3,000	\$6,000	\$12,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$5,000	\$7,500	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$10,000	\$15,000	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$60	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$60	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	\$60	\$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$3,000	Community	Encore Combined	Out-of-Network
Plan Code: CMP			
Benefit Category			
Annual Single Deductible	\$3,000	\$6,000	\$12,000
Annual Family Deductible	\$6,000	\$12,000	\$24,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,000	\$8,700	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$12,000	\$17,400	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$60	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$60	\$110	Ded, 50%
Chiropractic (12 visits annual max)	\$60	\$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$5,000	Community	Encore Combined	Out-of-Network
Plan Code: CMQ			
Benefit Category			
Annual Single Deductible	\$5,000	\$8,150	\$16,300
Annual Family Deductible	\$10,000	\$16,300	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,100	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,200	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$100	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, \$750	Ded, \$750	Ded, \$750
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$100	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	\$100	\$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$7,000	Community	Encore Combined	Out-of-Network
Plan Code: CMR			
Benefit Category			
Annual Single Deductible	\$7,000	\$8,500	\$16,300
Annual Family Deductible	\$14,000	\$17,000	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,200	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,400	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$3,200 - Embedded	Community	Encore Combined	Out-of-Network
Plan Code: CM7			
Benefit Category			
Annual Single Deductible	\$3,200	\$5,800	\$11,200
Annual Family Deductible	\$6,400	\$11,600	\$22,400
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,000	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$14,000	\$15,000	\$42,300
PCP Office	Ded, \$25	Ded, \$55	Ded, 50%
Specialist Office	Ded, \$60	Ded, \$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625	Ded, \$625
Urgent Care	Ded, \$100	Ded, \$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$60	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$60	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	Ded, \$25	Ded, \$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$5,000 - Embedded	Community	Encore Combined	Out-of-Network
Plan Code: CM8			
Benefit Category			
Annual Single Deductible	\$5,000	\$6,500	\$13,800
Annual Family Deductible	\$10,000	\$13,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,500	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$13,000	\$15,000	\$42,300
PCP Office	Ded, 10%	Ded, 30%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 30%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 30%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 30%	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$7,000 - Embedded	Community	Encore Combined	Out-of-Network
Plan Code: CM9			
Benefit Category			
Annual Single Deductible	\$7,000	\$7,500	\$13,800
Annual Family Deductible	\$14,000	\$15,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,500	\$8,000	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$15,000	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 30%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 30%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 30%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 30%	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Two Tier PPO



PPO \$1,500	Community	Out-of-Network
Plan Code: CMG		
Benefit Category		
Annual Single Deductible	\$1,500	\$6,000
Annual Family Deductible	\$3,000	\$12,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$5,000	\$27,300
Annual OOP max - family (inc ded, copay, coinsurance)	\$10,000	\$54,600
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$2,500	Community	Out-of-Network
Plan Code: CMH		
Benefit Category		
Annual Single Deductible	\$2,500	\$10,000
Annual Family Deductible	\$5,000	\$20,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$5,500	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$11,000	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$4,000	Community	Out-of-Network
Plan Code: CMJ		
Benefit Category		
Annual Single Deductible	\$4,000	\$16,000
Annual Family Deductible	\$8,000	\$32,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$6,000	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$12,000	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$40	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$40	Ded, 50%
Chiropractic (12 visits annual max)	\$40	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$6,000	Community	Out-of-Network
Plan Code: CMK		
Benefit Category		
Annual Single Deductible	\$6,000	\$16,300
Annual Family Deductible	\$12,000	\$32,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,250	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,500	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$40	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$40	Ded, 50%
Chiropractic (12 visits annual max)	\$40	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$7,000	Community	Out-of-Network
Plan Code: CML		
Benefit Category		
Annual Single Deductible	\$7,000	\$16,300
Annual Family Deductible	\$14,000	\$32,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$9,200	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$18,400	\$52,200
PCP Office	\$0	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$0	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$3,200 - Embedded	Community	Out-of-Network
Plan Code: CM3		
Benefit Category		
Annual Single Deductible	\$3,200	\$11,200
Annual Family Deductible	\$6,400	\$22,400
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,000	\$42,300
PCP Office	Ded, \$25	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, \$110	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, \$25	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$5,000 - Embedded	Community	Out-of-Network
Plan Code: CM4		
Benefit Category		
Annual Single Deductible	\$5,000	\$13,800
Annual Family Deductible	\$10,000	\$27,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,000	\$42,300
PCP Office	Ded, 10%	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, 10%	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$7,000 - Embedded	Community	Out-of-Network
Plan Code: CM5		
Benefit Category		
Annual Single Deductible	\$7,000	\$13,800
Annual Family Deductible	\$14,000	\$27,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$8,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, 10%	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Three Tier PPO



PPO \$1,500	Union Integrated	Encore Combined	Out-of-Network
Plan Code: UNE			
Benefit Category			
Annual Single Deductible	\$1,500	\$3,000	\$6,000
Annual Family Deductible	\$3,000	\$6,000	\$12,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$5,000	\$7,500	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$10,000	\$15,000	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$60	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$60	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$60	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$3,000	Union Integrated	Encore Combined	Out-of-Network
Plan Code: UNF			
Benefit Category			
Annual Single Deductible	\$3,000	\$6,000	\$12,000
Annual Family Deductible	\$6,000	\$12,000	\$24,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,000	\$8,700	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$12,000	\$17,400	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$55	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$55	\$110	Ded, 50%
Chiropractic (12 visits annual max)	\$55	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$5,000	Union Integrated	Encore Combined	Out-of-Network
Plan Code: UNG			
Benefit Category			
Annual Single Deductible	\$5,000	\$8,150	\$16,300
Annual Family Deductible	\$10,000	\$16,300	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,100	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$17,000	\$18,200	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$7,000	Union Integrated	Encore Combined	Out-of-Network
Plan Code: UNH			
Benefit Category			
Annual Single Deductible	\$7,000	\$8,500	\$16,300
Annual Family Deductible	\$14,000	\$17,000	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,200	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,400	\$52,200
PCP Office	\$0	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$0	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$3,200 - Embedded	Union Integrated	Encore Combined	Out-of-Network
Plan Code: UN7			
Benefit Category			
Annual Single Deductible	\$3,200	\$5,800	\$11,200
Annual Family Deductible	\$6,400	\$11,600	\$22,400
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,000	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$14,000	\$15,000	\$42,300
PCP Office	Ded, \$25	Ded, \$55	Ded, 50%
Specialist Office	Ded, \$60	Ded, \$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625	Ded, \$625
Urgent Care	Ded, \$100	Ded, \$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$60	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$60	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, \$25	Ded, \$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$5,000 - Embedded	Union Integrated	Encore Combined	Out-of-Network
Plan Code: UN8			
Benefit Category			
Annual Single Deductible	\$5,000	\$6,500	\$13,800
Annual Family Deductible	\$10,000	\$13,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,500	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$13,000	\$15,000	\$42,300
PCP Office	Ded, 10%	Ded, 20%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 20%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, 10%	Ded, 20%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 20%	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$7,000 - Embedded	Union Integrated	Encore Combined	Out-of-Network
Plan Code: UN9			
Benefit Category			
Annual Single Deductible	\$7,000	\$7,500	\$13,800
Annual Family Deductible	\$14,000	\$15,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,500	\$8,000	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$15,000	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 20%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 20%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, 10%	Ded, 20%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 20%	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$1,500	Good Samaritan	Encore Combined	Out-of-Network
Plan Code: GME			
Benefit Category			
Annual Single Deductible	\$1,500	\$3,000	\$6,000
Annual Family Deductible	\$3,000	\$6,000	\$12,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$5,000	\$7,500	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$10,000	\$15,000	\$52,200
PCP Office	\$30	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$60	\$110	Ded, 50%
Preventive Care	0%	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$60	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	\$60	\$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	\$30	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$3,000	Good Samaritan	Encore Combined	Out-of-Network
Plan Code: GMF			
Benefit Category			
Annual Single Deductible	\$3,000	\$6,000	\$12,000
Annual Family Deductible	\$6,000	\$12,000	\$24,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,000	\$8,700	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$12,000	\$17,400	\$52,200
PCP Office	\$30	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$60	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$60	\$110	Ded, 50%
Chiropractic (12 visits annual max)	\$60	\$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	\$30	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO

PPO \$5,000	Good Samaritan	Encore Combined	Out-of-Network
Plan Code: GMG			
Benefit Category			
Annual Single Deductible	\$5,000	\$8,150	\$16,300
Annual Family Deductible	\$10,000	\$16,300	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,100	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,200	\$52,200
PCP Office	\$35	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	\$35	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

Disclaimer: This is a draft of product offerings. The intention of this document is to provide an overview of the plans and does not include plan exclusions and limitations.

Three Tier PPO

PPO \$7,000	Good Samaritan	Encore Combined	Out-of-Network
Plan Code: GMH			
Benefit Category			
Annual Single Deductible	\$7,000	\$8,500	\$16,300
Annual Family Deductible	\$10,000	\$17,000	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,200	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,400	\$52,200
PCP Office	\$35	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	\$35	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA

HSA \$3,200 - Embedded	Good Samaritan	Encore Combined	Out-of-Network
Plan Code: GM3			
Benefit Category			
Annual Single Deductible	\$3,200	\$5,800	\$11,200
Annual Family Deductible	\$6,400	\$11,600	\$22,400
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,000	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$14,000	\$15,000	\$42,300
PCP Office	Ded, \$30	Ded, \$55	Ded, 50%
Specialist Office	Ded, \$60	Ded, \$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625	Ded, \$625
Urgent Care	Ded, \$100	Ded, \$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$60	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$60	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	Ded, \$30	Ded, \$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA

HSA \$5,000 - Embedded	Good Samaritan	Encore Combined	Out-of-Network
Plan Code: GM4			
Benefit Category			
Annual Single Deductible	\$5,000	\$6,500	\$13,800
Annual Family Deductible	\$10,000	\$13,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,500	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$13,000	\$15,000	\$42,300
PCP Office	Ded, 10%	Ded, 30%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 30%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 30%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 30%	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA

HSA \$7,000 - Embedded	Good Samaritan	Encore Combined	Out-of-Network
Plan Code: GM5			
Benefit Category			
Annual Single Deductible	\$7,000	\$7,500	\$13,800
Annual Family Deductible	\$14,000	\$15,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,500	\$8,000	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$15,000	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 30%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 30%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 30%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 30%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 30%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 30%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 30%	Ded, 50%
DME	Ded, 10%	Ded, 30%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 30%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 30%	Ded, 50%
Hospice	Ded, 10%	Ded, 30%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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CLINIC INFORMATION



Good Samaritan
Wellness Matters

**As part of the Good Samaritan Direct Health program,
Employers will automatically have access to the Wellness Matters Clinic.**

Visits to the Wellness Matters Clinic will be free of charge to all members of the plan as the cost of the program is included within the premium.

The clinic offers physicals, wellness exams, chronic care management, health maintenance, on-site lab draw & medications for all your acute and wellness needs.

Healthcare services offered:

- Physicals (Sports, School, Annual)
- DOT/CDL
- Well-Man or Woman Exams
- Pelvic Exams
- Chronic Care Management
- Health Maintenance
- Referrals for Screening Tests
- Mental Health Needs:
Depression, Anxiety, etc.
- Weight loss Counseling
- Birth Control
- Health Action Plans

Urgent Concerns:

- Splinter Removal
- Breathing Treatments
- Treatment of Minor Injuries & Illnesses
- Urinary Tract Infections
- Common Rashes
- Minor Respiratory Illness
- Ear Pain & Ear Wax Issues
- Pink Eye
- Sinus Pain
- Allergies
- STI Testing & Treatment
- Simple Abscesses / Boils

Hours:
Monday-Thursday
(8am-5pm)

Phone:
(812) 885-8945
Visits by Appointment Only

Medical Center of Vincennes
406 N. 1st Street
Vincennes, IN

Three Tier PPO



PPO \$1,500	Parkview Value Plus	Parkview Signature	Out-of-Network
Plan Code: PVF			
Benefit Category			
Annual Single Deductible	\$1,500	\$3,000	\$6,000
Annual Family Deductible	\$3,000	\$6,000	\$12,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$5,000	\$7,500	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$10,000	\$15,000	\$52,200
PCP Office	\$30	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$60	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$60	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$60	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$30	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$3,000	Parkview Value Plus	Parkview Signature	Out-of-Network
Plan Code: PVG			
Benefit Category			
Annual Single Deductible	\$3,000	\$6,000	\$12,000
Annual Family Deductible	\$6,000	\$12,000	\$24,000
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,000	\$8,700	\$26,100
Annual OOP max-family (inc ded, copay, coinsurance)	\$12,000	\$17,400	\$52,200
PCP Office	\$25	\$50	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$40	\$80	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$40	\$80	Ded, 50%
Chiropractic (12 visits annual max)	\$40	\$80	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$25	\$50	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$5,000	Parkview Value Plus	Parkview Signature	Out-of-Network
Plan Code: PVH			
Benefit Category			
Annual Single Deductible	\$5,000	\$8,150	\$16,300
Annual Family Deductible	\$10,000	\$16,300	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,100	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,200	\$52,200
PCP Office	\$35	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$35	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier PPO



PPO \$7,000	Parkview Value Plus	Parkview Signature	Out-of-Network
Plan Code: PVJ			
Benefit Category			
Annual Single Deductible	\$7,000	\$8,500	\$16,300
Annual Family Deductible	\$14,000	\$17,000	\$32,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$8,500	\$9,200	\$26,100
Annual OOP max -family (inc ded, copay, coinsurance)	\$17,000	\$18,400	\$52,200
PCP Office	\$35	\$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$80	\$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%	Ded, 10%
Urgent Care	\$100	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$80	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	\$80	\$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	\$35	\$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	\$15	\$15	Ded, 50%
Brand Name Formulary	\$45	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$3,200 - Embedded	Parkview Value Plus	Parkview Signature	Out-of-Network
Plan Code: PV4			
Benefit Category			
Annual Single Deductible	\$3,200	\$5,800	\$11,200
Annual Family Deductible	\$6,400	\$11,600	\$22,400
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,000	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$14,000	\$15,000	\$42,300
PCP Office	Ded, \$30	Ded, \$55	Ded, 50%
Specialist Office	Ded, \$60	Ded, \$110	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, \$100	Ded, \$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$60	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$60	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, \$30	Ded, \$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$5,000 - Embedded	Parkview Value Plus	Parkview Signature	Out-of-Network
Plan Code: PV5			
Benefit Category			
Annual Single Deductible	\$5,000	\$6,500	\$13,800
Annual Family Deductible	\$10,000	\$13,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$6,500	\$7,500	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$13,000	\$15,000	\$42,300
PCP Office	Ded, 10%	Ded, 20%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 20%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, 10%	Ded, 20%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 20%	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



HSA \$7,000 - Embedded	Parkview Value Plus	Parkview Signature	Out-of-Network
Plan Code: PV6			
Benefit Category			
Annual Single Deductible	\$7,000	\$7,500	\$13,800
Annual Family Deductible	\$14,000	\$15,000	\$27,600
Annual OOP max-single (inc ded, copay, coinsurance)	\$7,500	\$8,000	\$21,150
Annual OOP max-family (inc ded, copay, coinsurance)	\$15,000	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 20%	Ded, 50%
Specialist Office	Ded, 10%	Ded, 20%	Ded, 50%
Preventive Care	\$0	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 20%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care	Ded, 10%	Ded, 20%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 20%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 20%	Ded, 50%
DME	Ded, 10%	Ded, 20%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 20%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 20%	Ded, 50%
Hospice	Ded, 10%	Ded, 20%	Ded, 50%
Pharmacy			
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Ded, 30%	Not covered
Mail Order (90-day Supply)	2.5x	2.5x	Mail Order Only; Ded, 50%

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Two Tier PPO



PPO \$1,500	Parkview Value Plus	Out-of-Network
Plan Code: PVA		
Benefit Category		
Annual Single Deductible	\$1,500	\$6,000
Annual Family Deductible	\$3,000	\$12,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$5,000	\$27,300
Annual OOP max - family (inc ded, copay, coinsurance)	\$10,000	\$54,600
PCP Office	\$30	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$30	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$2,500	Parkview Value Plus	Out-of-Network
Plan Code: PVB		
Benefit Category		
Annual Single Deductible	\$2,500	\$10,000
Annual Family Deductible	\$5,000	\$20,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$5,500	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$11,000	\$52,200
PCP Office	\$30	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	\$500	\$500
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$30	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$4,000	Parkview Value Plus	Out-of-Network
Plan Code: PVC		
Benefit Category		
Annual Single Deductible	\$4,000	\$16,000
Annual Family Deductible	\$8,000	\$32,000
Annual OOP max - single (inc ded, copay, coinsurance)	\$6,000	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$12,000	\$52,200
PCP Office	\$15	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$30	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$30	Ded, 50%
Chiropractic (12 visits annual max)	\$30	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$15	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$6,000	Parkview Value Plus	Out-of-Network
Plan Code: PVD		
Benefit Category		
Annual Single Deductible	\$6,000	\$16,300
Annual Family Deductible	\$12,000	\$32,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$8,000	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$16,000	\$52,200
PCP Office	\$30	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$30	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier PPO



PPO \$7,000	Parkview Value Plus	Out-of-Network
Plan Code: PVE		
Benefit Category		
Annual Single Deductible	\$7,000	\$16,300
Annual Family Deductible	\$14,000	\$32,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$9,200	\$26,100
Annual OOP max - family (inc ded, copay, coinsurance)	\$18,400	\$52,200
PCP Office	\$30	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	\$90	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	\$100	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	\$90	Ded, 50%
Chiropractic (12 visits annual max)	\$90	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	\$30	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%
Brand Name Nonformulary	Ded, \$100	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$3,200 - Embedded	Parkview Value Plus	Out-of-Network
Plan Code: PV1		
Benefit Category		
Annual Single Deductible	\$3,200	\$11,200
Annual Family Deductible	\$6,400	\$22,400
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,000	\$42,300
PCP Office	Ded, \$55	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, \$110	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, \$110	Ded, 50%
Chiropractic (12 visits annual max)	Ded, \$110	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, \$55	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$5,000 - Embedded	Parkview Value Plus	Out-of-Network
Plan Code: PV2		
Benefit Category		
Annual Single Deductible	\$5,000	\$13,800
Annual Family Deductible	\$10,000	\$27,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$7,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$14,000	\$42,300
PCP Office	Ded, 10%	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, 10%	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Two Tier HSA



HSA \$7,000 - Embedded	Parkview Value Plus	Out-of-Network
Plan Code: PV3		
Benefit Category		
Annual Single Deductible	\$7,000	\$13,800
Annual Family Deductible	\$14,000	\$27,600
Annual OOP max - single (inc ded, copay, coinsurance)	\$8,000	\$21,150
Annual OOP max - family (inc ded, copay, coinsurance)	\$16,000	\$42,300
PCP Office	Ded, 10%	Ded, 50%
Specialist Office (Coinsurance for Ancillary Services)	Ded, 10%	Ded, 50%
Preventive Care	\$0	Not covered
Inpatient Hospital	Ded, 10%	Ded, 50%
Outpatient Hospital	Ded, 10%	Ded, 50%
Professional Services (Inpatient & Outpatient)	Ded, 10%	Ded, 50%
Emergency Room	Ded, 10%	Ded, 10%
Urgent Care	Ded, 10%	Ded, 50%
Ambulance	Ded, 10%	Ded, 10%
PT/OT/Speech (20 visit annual max each)	Ded, 10%	Ded, 50%
Chiropractic (12 visits annual max)	Ded, 10%	Ded, 50%
DME	Ded, 10%	Ded, 50%
Inpatient Behavior	Ded, 10%	Ded, 50%
Outpatient Behavior	Ded, 10%	Ded, 50%
Skilled Nursing (90 visits)	Ded, 10%	Ded, 50%
Acute Inpatient Rehab	Ded, 10%	Ded, 50%
Home Health (100 visits)	Ded, 10%	Ded, 50%
Hospice	Ded, 10%	Ded, 50%
Pharmacy		
Generic Drug	Ded, 10%	Ded, 50%
Brand Name Formulary	Ded, 10%	Ded, 50%
Brand Name Nonformulary	Ded, 10%	Ded, 50%
Specialty Drug	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order (90-day Supply)	2.5x	N/A

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Three Tier PPO



	PC Choice \$1,500			PC Choice \$3,000			PC Choice \$5,000			PC Choice \$7,000		
Plan Codes	LCD			LCE			LCF			LCG		
	Tier 1 Network	Tier 2 Network	Tier 3 Out-of-Network	Tier 1 Network	Tier 2 Network	Tier 3 Out-of-Network	Tier 1 Network	Tier 2 Network	Tier 3 Out-of-Network	Tier 1 Network	Tier 2 Network	Tier 3 Out-of-Network
Annual Single Deductible	\$1,500	\$3,000	\$6,000	\$3,000	\$6,000	\$12,000	\$5,000	\$8,150	\$16,300	\$7,000	\$8,200	\$16,300
Annual Family Deductible	\$3,000	\$6,000	\$12,000	\$6,000	\$12,000	\$24,000	\$10,000	\$16,300	\$32,600	\$14,000	\$16,400	\$32,600
Annual OOP Max - Single (incl Deductible, copay, coinsurance)	\$5,000	\$8,000	\$26,100	\$6,000	\$8,700	\$26,100	\$8,700	\$8,700	\$26,100	\$8,700	\$9,200	\$26,100
Annual OOP Max - Family (incl Deductible, copay, coinsurance)	\$10,000	\$16,000	\$52,200	\$12,000	\$17,400	\$52,200	\$17,400	\$17,400	\$52,200	\$17,400	\$18,400	\$52,200
PCP Office Visit	\$35	\$35	Ded, 50%	\$35	\$35	Ded, 50%	\$45	\$45	Ded, 50%	\$45	\$45	Ded, 50%
Specialist Office Visit	\$70	\$70	Ded, 50%	\$70	\$70	Ded, 50%	\$90	\$90	Ded, 50%	\$90	\$90	Ded, 50%
Preventive Care	0%	0%	Not Covered	0%	0%	Not Covered	0%	0%	Not Covered	0%	0%	Not Covered
Inpatient Hospital Services	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Outpatient Hospital Services	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Professional Services (In & Out)	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Emergency Room	\$500	\$500	\$500	\$500	\$500	\$500	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%
Urgent Care Facility	\$100	\$100	Ded, 50%	\$100	\$100	Ded, 50%	\$100	\$100	Ded, 50%	\$100	\$100	Ded, 50%
Ambulance	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%
PT/OT/Speech Therapy (20 visit annual max each)	\$70	Ded, 30%	Ded, 50%	\$70	Ded, 30%	Ded, 50%	\$90	Ded, 30%	Ded, 50%	\$90	Ded, 30%	Ded, 50%
Chiropractic Services (12 visit annual max)	\$70	\$70	Ded, 50%	\$70	\$70	Ded, 50%	\$90	\$90	Ded, 50%	\$90	\$90	Ded, 50%
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Inpatient Behavioral Health	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Outpatient Behavioral Health	\$35	\$35	Ded, 50%	\$35	\$35	Ded, 50%	\$45	\$45	Ded, 50%	\$45	\$45	Ded, 50%
Skilled Nursing Facility (90 visits)	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Long Term Acute Care	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Acute Inpatient Rehabilitation	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Hospice	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 20%	Ded, 30%	Ded, 50%
Pharmacy:												
Generic Drug	\$10	\$10	Ded, 50%	\$10	\$10	Ded, 50%	\$15	\$15	Ded, 50%	\$15	\$15	Ded, 50%
Brand Name Formulary	\$35	\$35	Ded, 50%	\$35	\$35	Ded, 50%	\$45	\$45	Ded, 50%	\$45	\$45	Ded, 50%
Brand Name Non-Formulary	\$70	\$70	Ded, 50%	\$70	\$70	Ded, 50%	Ded, \$100	Ded, \$100	Ded, 50%	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drugs *	Ded, 30%	Ded, 30%	Mail Order Only; Ded, 50%	Ded, 30%	Ded, 30%	Mail Order Only; Ded, 50%	Ded, 30%	Ded, 30%	Mail Order Only; Ded, 50%	Ded, 30%	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order	2.5x	2.5x	Mail Order Only; Ded, 50%	2.5x	2.5x	Mail Order Only; Ded, 50%	2.5x	2.5x	Mail Order Only; Ded, 50%	2.5x	2.5x	Mail Order Only; Ded, 50%

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Three Tier HSA



	HSA \$3,200			HSA \$5,000		
Plan Codes	LC3			LC4		
	Tier 1 Network	Tier 2 Network	Tier 3 Out-of- Network	Tier 1 Network	Tier 2 Network	Tier 3 Out-of- Network
Annual Single Deductible	\$3,200	\$5,800	\$11,200	\$5,000	\$6,500	\$13,800
Annual Family Deductible	\$6,400	\$11,600	\$22,400	\$10,000	\$13,000	\$27,600
Annual OOP Max - Single (incl Deductible, copay, coinsurance)	\$7,000	\$7,500	\$21,150	\$6,500	\$7,500	\$21,150
Annual OOP Max - Family (incl Deductible, copay, coinsurance)	\$14,000	\$15,000	\$42,300	\$13,000	\$15,000	\$42,300
Family Deductible / OOP Max	Embedded			Embedded		
PCP Office Visit	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Specialist Office Visit	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Preventive Care	0%	0%	Not Covered	0%	0%	Not Covered
Inpatient Hospital Services	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Outpatient Hospital Services	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Professional Services (In & Out)	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Emergency Room	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 0%	Ded, 0%	Ded, 0%
Urgent Care Facility	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Ambulance	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 0%	Ded, 0%	Ded, 0%
PT/OT/Speech Therapy (20 visit annual max each)	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Chiropractic Services (12 visit annual max)	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Inpatient Behavioral Health	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Outpatient Behavioral Health	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Skilled Nursing Facility (90 visits)	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Long Term Acute Care	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Acute Inpatient Rehabilitation	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Home Health (100 visits)	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Hospice	Ded, 20%	Ded, 30%	Ded, 50%	Ded, 0%	Ded, 30%	Ded, 50%
Pharmacy:						
Generic Drug	Ded, \$15	Ded, \$15	Ded, 50%	Ded, \$15	Ded, \$15	Ded, 50%
Brand Name Formulary	Ded, \$45	Ded, \$45	Ded, 50%	Ded, \$45	Ded, \$45	Ded, 50%
Brand Name Non-Formulary	Ded, 20%	Ded, 20%	Ded, 50%	Ded, \$100	Ded, \$100	Ded, 50%
Specialty Drugs *	Ded, 30%	Ded, 30%	Mail Order Only; Ded, 50%	Ded, 30%	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order	2.5x	2.5x	Mail Order Only; Ded, 50%	2.5x	2.5x	Mail Order Only; Ded, 50%

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Two Tier PPO



	PPO \$1,500		PPO \$2,500		PPO \$4,100	
Plan Codes	7AG		7AH		7AJ	
	Encore Combined	Out-of- Network	Encore Combined	Out-of- Network	Encore Combined	Out-of- Network
Annual Single Deductible	\$1,500	\$6,000	\$2,500	\$10,000	\$4,100	\$16,000
Annual Family Deductible	\$3,000	\$12,000	\$5,000	\$20,000	\$8,200	\$32,000
Annual OOP Max - Single (incl Deductible, copay, coinsurance)	\$5,000	\$27,300	\$5,500	\$26,100	\$6,000	\$26,100
Annual OOP Max - Family (incl Deductible, copay, coinsurance)	\$10,000	\$54,600	\$11,000	\$52,200	\$12,000	\$52,200
PCP Office Visit	\$30	Ded, 50%	\$30	Ded, 50%	\$20	Ded, 50%
Specialist Office Visit	\$75	Ded, 50%	\$75	Ded, 50%	\$40	Ded, 50%
Preventive Care	\$0	\$0	\$0	\$0	\$0	Not Covered
Inpatient Hospital Services	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Outpatient Hospital Services	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Professional Services (In & Out)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Emergency Room	\$500	\$500	\$500	\$500	\$500	\$500
Urgent Care Facility	\$100	Ded, 50%	\$100	Ded, 50%	\$100	Ded, 50%
Ambulance	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%
PT/OT/Speech Therapy (20 visit annual max each)	\$75	Ded, 50%	\$75	Ded, 50%	\$40	Ded, 50%
Chiropractic Services (12 visit annual max)	\$75	Ded, 50%	\$75	Ded, 50%	\$40	Ded, 50%
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Inpatient Behavioral Health	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Outpatient Behavioral Health	\$30	Ded, 50%	\$30	Ded, 50%	\$20	Ded, 50%
Skilled Nursing Facility (90 visits)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Long Term Acute Care	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Acute Inpatient Rehabilitation	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Hospice	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Pharmacy:						
Generic Drug	Ded, \$15	Ded, 50%	\$15	Ded, 50%	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%	\$45	Ded, 50%	\$45	Ded, 50%
Brand Name Non-Formulary	Ded, \$100	Ded, 50%	Ded, \$100	Ded, 50%	Ded, \$100	Ded, 50%
Specialty Drugs *	Ded, 30%	Mail Order Only; Ded, 50%	Ded, 30%	Mail order only, Ded, 50%	Ded, 30%	Mail Order Only; Ded, 50%
Mail Order	2.5x	2.5x	2.5x	2.5x	2.5x	Mail Order Only; Ded, 50%

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Two Tier PPO



Plan Codes	PPO \$6,000		PPO \$7,000	
	7AK		7AL	
	Encore Combined	Out-of-Network	Encore Combined	Out-of-Network
Annual Single Deductible	\$6,000	\$16,300	\$7,000	\$16,300
Annual Family Deductible	\$12,000	\$32,600	\$14,000	\$32,600
Annual OOP Max - Single (incl Deductible, copay, coinsurance)	\$8,700	\$26,100	\$9,200	\$26,100
Annual OOP Max - Family (incl Deductible, copay, coinsurance)	\$17,400	\$52,200	\$18,400	\$52,200
PCP Office Visit	\$30	Ded, 50%	\$30	Ded, 50%
Specialist Office Visit	\$75	Ded, 50%	\$75	Ded, 50%
Preventive Care	\$0	Not Covered	\$0	Not Covered
Inpatient Hospital Services	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Outpatient Hospital Services	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Professional Services (In & Out)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$500	Ded, \$500	Ded, \$500	Ded, \$500
Urgent Care Facility	\$100	Ded, 50%	\$100	Ded, 50%
Ambulance	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%
PT/OT/Speech Therapy (20 visit annual max each)	\$75	Ded, 50%	\$75	Ded, 50%
Chiropractic Services (12 visit annual max)	\$75	Ded, 50%	\$75	Ded, 50%
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Inpatient Behavioral Health	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Outpatient Behavioral Health	\$30	Ded, 50%	\$30	Ded, 50%
Skilled Nursing Facility (90 visits)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Long Term Acute Care	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Acute Inpatient Rehabilitation	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Hospice	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Pharmacy:				
Generic Drug	Ded, \$15	Ded, 50%	\$15	Ded, 50%
Brand Name Formulary	\$45	Ded, 50%	\$45	Ded, 50%
Brand Name Non-Formulary	Ded, \$100	Ded, 50%	Ded, \$100	Ded, 50%
Specialty Drugs *	Ded, 30%	Mail Order Only; Ded, 50%	Ded, 30%	Mail order only, Ded, 50%
Mail Order	2.5x	2.5x	2.5x	2.5x

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Two Tier HSA



	HSA \$3,200		HSA \$5,500		HSA \$7,000	
Plan Codes	7A3		7A4		7A6	
	Encore Combined	Out-of- Network	Encore Combined	Out-of- Network	Encore Combined	Out-of- Network
Annual Single Deductible	\$3,200	\$11,200	\$5,500	\$13,800	\$7,000	\$13,800
Annual Family Deductible	\$6,400	\$22,400	\$11,000	\$27,600	\$14,000	\$27,600
Annual OOP Max - Single (incl Deductible, copay, coinsurance)	\$7,000	\$21,150	\$8,000	\$21,150	\$8,000	\$21,150
Annual OOP Max - Family (incl Deductible, copay, coinsurance)	\$14,000	\$42,300	\$16,000	\$42,300	\$16,000	\$42,300
PCP Office Visit	Ded, \$35	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Specialist Office Visit	Ded, \$70	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Preventive Care	\$0	Not Covered	\$0	Not Covered	\$0	Not Covered
Inpatient Hospital Services	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Outpatient Hospital Services	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Professional Services (In & Out)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Emergency Room	Ded, \$625	Ded, \$625	Ded, \$1,600	Ded, \$1,600	Ded, \$1,250	Ded, \$1,250
Urgent Care Facility	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Ambulance	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%	Ded, 20%
PT/OT/Speech Therapy (20 visit annual max each)	Ded, \$70	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Chiropractic Services (12 visit annual max)	Ded, \$70	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Inpatient Behavioral Health	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Outpatient Behavioral Health	Ded, \$35	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Skilled Nursing Facility (90 visits)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Long Term Acute Care	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Acute Inpatient Rehabilitation	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Home Health (100 visits)	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Hospice	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Pharmacy:						
Generic Drug	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Brand Name Formulary	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Brand Name Non-Formulary	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%	Ded, 20%	Ded, 50%
Specialty Drugs *	Ded, 30%	Mail order only, Ded, 50%	Ded, 30%	Mail order only, Ded, 50%	Ded, 30%	Mail order only, Ded, 50%
Mail Order	2.5x	2.5x	2.5x	2.5x	2.5x	2.5x

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READY FOR A QUOTE?

Required Items to Quote:

1 Employer Information

- A) Employer's Name
- B) Employer's Address
- C) Employer's County

2 Effective Date

3 Census

- A) Employee's Name & DOB
- B) Dependent's Name(s) & DOB(s)
- C) Spouse's Name & DOB
- D) Employee's Zip Code



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