Medical Plans

You can only make changes to benefits during open enrollment or if you experience a qualifying life event. Coverage is provided through Anthem network.

MEDICAL PLAN OPTION	TRADITIONAL PLAN		HEALTH SAVINGS PLAN		ANTHEM HRA (non-exempt employees only)	
	In-Network	Out-of-Network[5]	In-Network	Out-of-Network[5]	In-Network	Out-of-Network[5]
Annual Deductible[1]	$500 per person $1,500 per family	$2,000 per person $6,000 per family	$2,000 employee-only coverage $4,000 family coverage[6]	$4,000 employee-only coverage $8,000 family coverage[6]	$750 employee-only coverage (HRA account pays the first $500) $1,500 family coverage (HRA account pays the first $1,000)	$750 employee-only coverage (HRA account pays the first $500) $1,500 family coverage (HRA account pays the first $1,000)
Physician Visits[2]	$30 PCP copay $40 Specialist copay (Copay for office visit exam fee only. Coinsurance may apply to other services.)	60% of non-network reimbursement rate after deductible	80% after deductible	60% of non-network reimbursement rate after deductible	80% after deductible	60% of non-network reimbursement rate after deductible
Testing and Ancillary Services[2]	100% coverage for age appropriate testing related to preventive care 80% coinsurance applies to other charges after deductible	60% of non-network reimbursement rate after deductible	100% coverage for age appropriate testing related to preventive care 80% after deductible	60% of non-network reimbursement rate after deductible	100% coverage for age appropriate testing related to preventive care; 80% after deductible	60% of non-network reimbursement rate after deductible
Emergency Room	80% after $300 ER visit copay	80% after $300 ER visit copay	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Hospital Admission/ Outpatient Surgery	80% after deductible and $300 hospital admission copay 80% after deductible and $150 outpatient copay	60% of non-network reimbursement rate after deductible	80% after deductible	60% of non-network reimbursement rate after deductible	80% after deductible	60% of non-network reimbursement rate after deductible
Retail Prescriptions (30-day supply)[4]	**Generic:** $12 **Preferred Brand:** $40 **Non-Preferred:** $80	Not covered	80% after deductible; CVS Caremark HDHP Preventitive Drug List: **Generic:** $10 **Brand:** $25	Not covered	**Generic:** $10 **Preferred Brand:** $30 **Non-Preferred:** $50	Must submit reimbursment claim form
Mail Order Prescriptions (90-day supply)[4]	**Generic:** $30 **Preferred Brand:** $100 **Non-Preferred:** $200	Not covered	80% after deductible; CVS Caremark HDHP Preventitive Drug List: **Generic:** $10 **Brand:** $25	Not covered	**Generic:** $20 **Preferred Brand:** $60 **Non-Preferred:** $100	Not covered

Medical Plans *(Continued)*

MEDICAL PLAN OPTION	TRADITIONAL PLAN		HEALTH SAVINGS PLAN		ANTHEM HRA (non-exempt employees only)	
	In-Network	Out-of-Network[5]	In-Network	Out-of-Network[5]	In-Network	Out-of-Network[5]
Specialty Mail Order Prescriptions (30-day supply)	**Generic:** $75 **Preferred Brand:** $150 **Non-Preferred:** $225	Not covered	80% after deductible	Not covered	$100 per prescription filled	Not covered
Out-of-Pocket Maximum[2]	$6,000 per person $12,000 per family [3] (Maximum per individual is $6,000) [3]	$25,000 per person $50,000 per family [3]	$6,000 employee-only coverage $12,000 family coverage [3] (Maximum per individual is $6,000) [3]	$25,000 employee-only coverage $50,000 family coverage [3]	$1,500 employee-only coverage $3,000 family coverage	$3,000 employee only coverage $6,000 family coverage
Bi-weekly Premiums	**Employee Only:** $76.15 **Employee and Spouse:** $163.38 **Employee and Children:** $144.46 **Employee and Family:** $251.08		**Employee Only:** $33.64 **Employee and Spouse:** $108.90 **Employee and Children:** $78.54 **Employee and Family:** $146.93		**Employee Only:** $57.49 **Employee and Spouse:** $138.59 **Employee and Children:** $91.11 **Employee and Family:** $179.49	

[1] In-network expenses do not apply to out-of-network out-of-pocket maximums (OOPM). Out-of-network expenses do not apply to in-network OOPM. For the Traditional Plan, deductibles, coinsurance and copays count toward satisfying OOPM. For the Health Savings Plan option, deductibles and coinsurance count toward satisfying OOPM.

[2] Preventive care is not covered out of network, except for the HRA plan which is 60% of non-network reimbursement rates.

[3] Plan benefits start paying at 100 percent for a covered individual once that person reaches the individual OOPM. If you have family coverage, your family does not have to meet the family OOPM before the plan will pay at 100 percent for a person who has met the individual OOPM.

[4] General provisions: Reimbursement is limited to non-excluded drugs per the current formulary and to the generic drug benefit when a non-generic is utilized. Participants will pay the lesser of the copay or the actual cost of the drug. Mail order prescriptions are available in a 90-day supply, except specialty drugs, which are only available in a 30-day supply. Drugs that have not been evaluated and approved by CVS Caremark's Pharmacy and Therapeutics Committee (or other appropriate reviewing body) or drugs that have been excluded from the formulary are not eligible for coverage.

[5] In-Network vs. Out-of-Network: You pay less when you use in-network providers - doctors, hospitals and pharmacies that are in the plan. When you and your family use these providers, you save money because network providers have agreed to accept negotiated rates for their services and you pay a lower portion of coinsurance and deductibles.

[6] For the Health Savings Plan, the family deductible must be met before any benefits are payable if you have enrolled any family members in addition to yourself. The deductible does not apply to covered preventive care services.

Dental Plan

DENTAL PLAN OPTION	DENTAL PPO Administered by Delta Dental of Texas (with orthodontia)
Choosing a Primary Care Dentist	You may choose any dentist. However, Delta Dental participating dental providers provide services that are not subject to a deductible and agree to accept negotiated, discounted rates that are within the recognized charge limits.
Non-Network Benefits	Plan offers non-network benefits subject to deductibles and reasonable and customary limits.
Filing of Claims	You or your dentist will submit claims.
Accessing Specialty Care	You may choose any dentist. However, Delta Dental providers stay within reasonable and customary limits and offer discounted care.
Emergency Care	You may choose any dentist. However, Delta Dental providers stay within reasonable and customary limits and offer discounted care.
Deductibles	**Network:** None **Non-Network:** $50 per person for Basic & Major Restorative Services
Coinsurance or Copays for Services	No copay for office visits. **Preventive:** 100% coverage **Basic Restorative:** 80% coverage **Major Restorative:** 60% coverage
Maximum Annual Benefit	$1,800 per person
Orthodontic Coverage	Plan pays 50% to a maximum of $1,600 per child (lifetime max). Dependent children under age 19 only.
Bi-weekly Premiums	**Employee Only:** $4.38 **Employee and Spouse:** $8.54 **Employee and Children:** $11.31 **Employee and Family:** $15.92

Network vs. Non-Network Dental Benefits

You may choose any dentist with the PPO plan. There is no deductible if you choose network dental providers who generally charge patients about 25 percent less for covered services. Non-network care is subject to a $50 deductible for restorative care and benefits are subject to recognized charge limits.

To locate a Network Dentist:

To locate PPO dentists and their provider ID, go to **deltadentalins.com**.

Vision Plan

All employees are eligible for coverage through Vision Service Plan (VSP), which includes an annual eye exam and either one pair of glasses or contact lenses every 12 months (subject to copays and certain limits and restrictions).

BENEFIT	NETWORK COVERAGE	NON-NETWORK COVERAGE
Comprehensive Vision Exam (once every calendar year)	100% covered after $10 copay.	Reimbursement up to $45 after $10 copay is applied.
Prescription Glasses (once every calendar year)	$25 materials copay, which is a single payment that is applied to the entire purchase, not the lens and frame individually.	
	Lenses: 100% covered after materials copay. Patient options not covered by the plan, such as some progressive lenses, photochromic lenses, UV protection and anti-reflective coatings, may be purchased through the plan at a 20-25% discount. Standard progressive lenses are now covered at a $0 copay.	**Lenses:** Reimbursement after copay is applied: • Single vision up to $30 • Lined Trifocal up to $65 • Lined Bifocal up to $50
	Frames: $180 retail frame allowance, and 20% off any out-of-pocket costs.	**Frames:** Reimbursement up to $70 after copay is applied.
Contact Lenses (once every calendar year)	Contact lenses may be selected in lieu of prescription glasses.	
	Elective: When you choose contacts instead of glasses, your $180 contact lens allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam, which is discounted 15%, is in addition to your vision exam to ensure the proper fit of contacts. If you choose contact lenses, you will be eligible for prescription glasses during the next calendar year.	Reimbursement up to $105 for elective contact lenses and contact lens exam.
	Medically Necessary: Medically necessary contacts prescribed for certain conditions are 100% covered after $25 copay. VSP doctor must receive approval from VSP prior to dispensing.	Reimbursement up to $210 for medically necessary contact lenses and contact lens exam.
Laser Eye Surgery	VSP participants receive PRK, LASIK and Custom LASIK at a discounted fee. Discounts vary by location, but will average 15% off of the contracted laser center's usual and customary price. Additionally, if the participating laser center is offering a temporary price reduction, VSP members will receive 5% off the promotional price.	Not covered
Bi-weekly Premiums	**Employee Only:** $3.32 **Employee and Spouse:** $7.02 **Employee and Children:** $7.52 **Employee and Family:** $10.40	

Create an account on **vsp.com** to view your in-network coverage and to find a VSP network doctor.