

Summary of Medical Benefits - Health Advantage		
Benefit	POS 302x (dependents are covered to age 26)	
	In-Network	Out-of-Network
DEDUCTIBLES AND MAXIMUMS		
Contract Year Deductible		
Individual	\$500	\$1,500
Family	\$1,500	\$4,500
Coinsurance	80%	60%
Out-of-Pocket Maximum (includes deductible)		
Individual	\$2,500	\$9,500
Family	\$7,500	\$28,500
Lifetime Benefit Maximum	UNLIMITED	UNLIMITED
COVERED SERVICES		
Office Visits		
Primary Care Physician	\$25 co-pay	Deductible + Coinsurance
Specialist	\$35 co-pay	Deductible + Coinsurance
Emergency Medical Care		
Emergency Room	\$100 co-pay + 20%	\$100 co-pay + 20%
Ambulance	Deductible + 50%	Deductible + 50%
Hospital Services		
Inpatient Services	\$200 co-pay + Deductible + 20%	Deductible + Coinsurance
Outpatient Services	\$100 co-pay + Deductible + 20%	Deductible + Coinsurance
Your Prescription Plan Co-Payments		
Generics	\$10	\$10
Preferred Brands	\$30	\$30
Non-Preferred Brands	\$50	\$50

Summary of Dental Benefits - Delta Dental	
Benefit	Coverage
Dependents covered to age 26.	In-Network
DEDUCTIBLES AND MAXIMUMS	
Calendar Year Deductible	
Individual	\$50 per person
Annual Benefit Maximum	

Individual	\$1,500
Family	\$1,500 per person
COVERED SERVICES	
Preventive Care (cleaning, x-rays, fluoride)	100%
Basic Services (lab tests, fillings, extractions, space)	80%
Major Services (crowns, bridges, dentures, inlays,	50%
ADDITIONAL BENEFITS	
CARRY OVER BENEFIT:	<ul style="list-style-type: none"> •Member receives annual maximum January 1st. •Member must have one covered dental service during the year. •Paid claims for the benefit year must be less than half of the annual maximum. •A quarter of the annual maximum will be carried over for future use. •Carry Over Benefit Maximum is up to \$3,000.
LIMITATIONS:	The benefit allowance for services of an out of network dentist will be reduced by 10% for eligible services as

Summary of Vision Benefits - Delta Vision	
Benefits for exams, frames, and lenses are provided every 12 months.	
	In-Network
Eye Examinations	\$10
Prescription Lenses	
Single Vision Lenses	\$25
Lined Bifocal Vision Lenses	\$25
Lined Trifocal Vision Lenses	\$25
Lenticular Lenses	
Frames	covered within plan allowance
Progressive Lenses	Up to 20% off retail, plus \$50 allowance
Contacts (in lieu of glasses)	
Medical Necessity	Prior authorization required
Elective	\$110 allowance