



PLANS	BSC 100-B \$20; Medco 7-25		BSC 90-E \$20; Medco 7-25		BSC 80-G \$30; Medco 9-35	
Calendar Year Deductible(s)	\$100 per individual/\$300 per family		\$300 per individual/\$600 per family		\$500 per individual/\$1,000 per family	
Maximum *Co-Insurance	Not applicable		\$600 per individual/\$1,800 per family		\$1,000 per individual/\$3,000 per family	
<i>Co-insurance is the member's responsibility to pay when the plan is paying less than 100% (i.e. plan pays 80%, member pays the other 20%)</i>	Not applicable		<i>Once the member's 10% co-insurance totals \$600 per individual, the plan will pay 100% of the allowable amount for the remainder of the calendar year.</i>		<i>Once the member's 20% co-insurance totals \$1,000 per individual, the plan will pay 100% of the allowable amount for the remainder of the calendar year.</i>	
Services	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Office Visits	Ded Waived \$20 co-pay	50%	Ded Waived \$20 co-pay	50%	Ded Waived \$30 co-pay	50%
Inpatient Hospital Room, Board & Support Services (prior authorization required)	100%	\$600 per day	90%	\$600 per day	80%	\$600 per day
Ambulatory Surgery Center	100%	\$350 per day	90%	\$350 per day	80%	\$350 per day
Emergency Room (non-emergency) Facility Expenses:	\$100 co-pay		\$100 co-pay		\$100 co-pay	
Professional Expenses:	100%	100% eligible expenses	90%	90% eligible expenses	80%	50%
		50%	90%	50%	80%	50%
Surgeon & Anesthetist	100%	50%	90%	50%	80%	50%
Accident Care (Professional) (initial care)	100%	100%	90%	90%	80%	80%
Preventative Care	Deductible Waived, 100%	50%	Deductible Waived, 100%	50%	Deductible Waived, 100%	50%
Routine Exam	Deductible Waived, 100%	Not Covered	Deductible Waived, 100%	Not Covered	Deductible Waived, 100%	Not Covered
Diagnostic X-Ray & Lab	100%	50%	90%	50%	80%	50%
Chiropractic	20 visits per year		20 visits per year		20 visits per year	
	100%	50%	90%	50%	80%	50%
Physical Medicine (PT, OT)	100%	50%	90%	50%	80%	50%
Speech Therapy	100%	50%	90%	50%	80%	50%
Acupuncture 12 visits per year	100% up to \$50 per visit	50% up to \$25 per visit	90% up to \$50 per visit	50% up to \$25 per visit	80% up to \$50 per visit (\$30 per visit HDHP*)	50% up to \$25 per visit (\$30 per visit HDHP*)
Durable Medical Equipment	100%	50%	90%	50%	80%	50%
Hearing Aid (\$700 maximum every 24 months)	100%	100%	90%	90%	80%	80%
Hospice	100%	Not Covered unless pre authorized	90%	Not Covered unless pre authorized	80%	Not Covered unless pre authorized
Ambulance	100%	100%	90%	90%	80%	80%
Home Health Care 100 visits/yr (prior authorization required)	100%	Not Covered unless pre authorized	90%	Not Covered unless pre authorized	80%	Not Covered unless pre authorized
Psychiatric Inpatient	100%	\$600 per day	90%	\$600 per day	80%	\$600 per day
Outpatient Visits For Severe Conditions	Same as Office Visit	50%	Same as Office Visit	50%	Same as Office Visit	50%
Outpatient Visits For Non-Severe Conditions						
Substance Abuse Inpatient For Acute Detox	100%	\$600 per day	90%	\$600 per day	80%	\$600 per day
Outpatient Visits	Same as Office Visit	50%	Same as Office Visit	50%	Same as Office Visit	50%
Outpatient Prescription Drugs	Rx Plan		Rx Plan		Rx Plan	
	Retail	Mail	Retail	Mail	Retail	Mail
Supply	30 days	90 days	30 days	90 days	30 days	90 days
Generic Drugs	\$7	\$14	\$7	\$14	\$9	\$18
Single Souce Brand Name Drugs	\$25	\$60	\$25	\$60	\$35	\$90
Brand Name Calendar Year Deductible	Not applicable		Not applicable		Not applicable	