

BENEFITS AT A GLANCE

Policy Number

247700-AVI

Medical Benefits - Plan 3

Weekly Rates

Inpatient Benefits		Outpatient Benefits ¹	
Standard Care Maximum	\$700 per day	Annual Outpatient Maximum	\$2,250
Intensive Care Unit Maximum ²	\$800 per day	Physician Office Visit	\$100 per day
Inpatient Surgery	\$4,000 per day	Diagnostic Lab	\$75 per day
Anesthesiology	\$800 per day	Diagnostic X-ray	\$200 per day
First Hospital Admission (one per year)	\$500	Ambulance Services	\$300 per day
Skilled Nursing payable for stays in a skilled nursing facility after a hospital stay	\$100 per day	Physical, Occupational, and Speech Therapy	\$50 per day
		Emergency Room - Sickness	\$200 per day
		Emergency Room - Accident	\$1000 per day
Prescription Drug ³		Outpatient Surgery	\$1000 per day
Prescription Drug Annual Maximum	\$600	Anesthesiology	\$400 per day
Prescription Drug Benefits	\$15 per day		
Wellness Care			
Wellness Care (one per year)	\$100		
Employee Only	\$31.28	Employee + One	\$63.48
		Employee + Family	\$84.77

¹ all outpatient benefits are subject to the outpatient maximum ² pays in addition to standard care benefit ³ not subject to outpatient maximum

Dental Benefits

Weekly Rates

	Waiting Period	Co-insurance	Annual Maximum Benefit	\$750	Deductible	\$50
Coverage A	None	80%	Exams, Cleanings, Intraoral Films and Bitewings			
Coverage B	3 months	60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures			
Coverage C	12 months	50%	Periodontics, Crowns, Bridges, Endodontics and Dentures			
Employee Only	\$5.23	Employee + One	\$10.46	Employee + Family		\$17.26

Vision Benefits

Weekly Rates

	In-Network	Out-of-Network
Eye Examination for Glasses ¹ (including dilation)	Co-pay: \$10, plan pays 100%	Plan pays \$35, you pay remaining balance
Frames ²	Plan pays \$110 allowance ⁴	Plan pays \$55
Standard Plastic Lenses for Glasses ¹	Co-pay: \$25, plan pays 100%	Co-pay: \$0, plan pays \$25-\$55 ³
Standard Contact Lens Fit ¹	Plan pays up to \$55	You pay 100% of the price
Premium Contact Lens Fit ¹	Plan pays 10% off the price	You pay 100% of the price
Contact Lenses or Disposable Lenses ¹	Plan pays \$110 allowance ⁴	Plan pays \$88
Contact Lenses Medically Necessary ¹	Plan pays 100%	Plan pays \$200
Employee Only	\$2.35	Employee + One
		\$4.00
		Employee + Family
		\$5.64

¹ Once every 12 months ² Once every 24 months ³ Single Vision: \$25, Bifocal: \$40, Trifocal: \$55

⁴ Discount on balance above allowed amount; Frames: 20%, Conventional Contact Lenses: 15%

Short-Term Disability

Weekly Rates

Benefit	60% of Salary up to \$150 per week	Waiting Period / Maximum Benefit Period	7 days / 26 weeks
Employee Only	\$4.20		

Term Life Benefits

Weekly Rates

Employee Amount	\$10,000 (reduces to \$7,500 at 65; \$5,000 at age 70)	Child Amount (6 months to 26 years old)	\$5,000
Spouse Amount	\$5,000 (terminates at age 70)	Infant Amount (15 days to 6 months)	\$1,000
Accidental Death and Dismemberment Benefit			
Employee Amount	\$20,000	Child Amount (6 months to 26 years old)	\$5,000
Spouse Amount	\$20,000	Infant Amount (15 days to 6 months)	\$2,500
Employee Only	\$0.60	Employee + One	\$0.90
		Employee + Family	\$1.80