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
Prescription Drug [3]		**Emergency Room - Accident**	$1000 per day
Prescription Drug Annual Maximum	$600	**Outpatient Surgery**	$1000 per day
Prescription Drug Benefits	$15 per day	**Anesthesiology**	$400 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**