



EMPLOYEE BENEFIT PLAN SUMMARY - 2017

MEDICAL PLAN DESIGN FEATURES	IN- NETWORK (PPO)	OUT-OF-NETWORK
Calendar Year Benefit Maximum	NONE	
First Dollar Benefit - Individual	Plan Pays 100% of First \$500	N/A
Family	Plan Pays 100% of First \$1,000	N/A
Calendar Year Deductible - Individual	\$750	
Family	\$1,500	
Annual Out of Pocket Maximum **	** (Including Deductible, Coinsurance, and Prescription Co-Pays)	
Individual	\$5,500	Unlimited
Family	\$11,000	Unlimited
Co-insurance Percentage	Plan Pays 80%	Plan Pays 60%
COVERED MEDICAL EXPENSES (CO-INSURANCE APPLIES BASED ON NETWORK STATUS OF PROVIDER)		
In-patient Hospital Expenses (If Out of Network a \$500 per confinement additional deductible will apply)	Hospital room charges and other in-hospital service charges. (Notification of American Health Holding at 800-641-5566 is required within 48 hours of an emergency admission, or at least five days prior to a scheduled hospital admission, or benefits may be reduced.)	
Hospital Emergency Room	Facility charges, emergency room physician charges, and ambulance charges. In an emergency situation, Out of Network hospital emergency room charges will be paid as In-Network.	
Helping Hands Physician Office Visit	\$25 Co-pay	
Physician Services (Including Urgent Care)	Office Visit, examination, allergy testing, surgery and injections.	
Lab/Imaging	Charges incurred in a physician's office, free-standing lab and imaging provider, or out-patient hospital facility for stipulated diagnostic medical procedures such as MRI's and CT Scans.	
Imaging - Hunt Regional Open Imaging	100% -You Must present your Hunt Regional VIP Card at time of Service. Applies to MRI, CT, Radiology and Ultrasound - Must have Doctors Orders	
Out-patient Surgery	Charges incurred in an out-patient hospital surgical center or an ambulatory surgical center.	
Maternity	Prenatal, delivery and routine new-born care.	
Mental and Nervous Disorders, Substance Abuse and Chemical Dependency	As any illness.	
Chiropractic Care	\$1,000 benefit maximum per calendar year	
Hearing Benefit	Screening paid at 100% to an annual maximum of \$100. Hearing aid limited to one purchase per calendar year, and paid at 80% of usual charge for both In- Network and Out of Network Network providers, and a lifetime benefit maximum of \$10,000.	
COVERED WELLNESS AND PREVENTIVE EXPENSES		
Routine physician examination, screenings, immunizations, lab, imaging and testing (Does not include diagnostic or treatment services).	In-Network charges paid at 100% with no calendar year deductible or annual limit on benefits. Benefits are not provided for Out-of Network charges.	



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COVERED PRESCRIPTION DRUG EXPENSES

Retail Pharmacy - 30 Day Supply					
Generic	15% (Minimum \$ 0 - Maximum \$ 50)				
Preferred Name Brand (Formulary)	30% (Minimum \$30 - Maximum \$ 90)				
Non-Preferred Name Brand	50% (Minimum \$60 - Maximum \$ 125)				
Specialty Drugs	50% (Minimum \$60 - Maximum \$ 125)				
Mail Order and 90 Day Retail Pharmacy - 90 Day Supply					
Generic	15% (Minimum \$ 0 - Maximum \$ 100)				
Preferred Name Brand (Formulary)	30% (Minimum \$ 60 - Maximum \$ 180)				
Non-Preferred Name Brand	50% (Minimum \$120 - Maximum \$ 250)				
Specialty Drugs	50% (Minimum \$120 - Maximum \$ 250)				
Generic Substitution Provision	If the physician prescribes a Name Brand drug, or the patient requests a Name Brand drug for which there is a substitutable Generic drug, the patient will be required to pay the difference between the Name Brand and Generic drug in addition to the Name Brand drug co-pay amount.				
Over the Counter \$0 Co-pay Provision (Prescription required)	<table border="0"> <tr> <td>Prilosec</td> <td>Claritin and Claritin D</td> </tr> <tr> <td>Zyrtec and Zyrtec D</td> <td>Allegra and Allegra D</td> </tr> </table>	Prilosec	Claritin and Claritin D	Zyrtec and Zyrtec D	Allegra and Allegra D
Prilosec	Claritin and Claritin D				
Zyrtec and Zyrtec D	Allegra and Allegra D				
Drugs Requiring Step Therapy	Proton Pump Inhibitors (acid reflux) Cholesterol Medications Bisphosphonates (bone density) COX-2 (pain) Sleep aids				

COVERED VISION EXPENSES

Annual Eye Examination	Paid at 100% to an annual benefit of \$50
Frames and Lenses	Paid at 100% to an annual benefit of \$250

COVERED DENTAL EXPENSES

Calendar Year Benefit Maximum	\$2,000
Lifetime Orthodontic Benefit Maximum	\$2,000 (Benefits provided only for children to age 19)
Calendar Year Deductible	\$50
Co-insurance - Preventive Services	100% - No calendar year deductible applied
Basic Services	80% after satisfying the calendar year deductible
Major Services	50% after satisfying the calendar year deductible
Orthodontic Services	50% after satisfying the calendar year deductible

The County of Rockwall is not a 'grandfathered' plan under the provisions of PPACA, and has been modified to be in full compliance with all of the regulations and guidance provided by The Department of Health and Human Services since the law took effect.