

# 2018 Medical Schedule of Benefits



Medical	Plus		Advantage	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Choice of Hospitals and Doctors	PPO Providers	Any other Provider	PPO Providers	Any other Provider
Annual Deductible				
Individual	\$0	\$0	\$600	\$600
Family	\$0	\$0	\$1,800	\$1,800
Maximum Out-of-Pocket (after deductible)				
Individual	\$1,000	No maximum	\$2,000	No maximum
Family	\$2,000		\$4,000	
Valley Children's Services:				
•Outpatient Lab and X-ray*	\$15 co-pay per visit	N/A	\$15 co-pay per visit	N/A
•Valley Children's Imaging * (MRI, CT, Nuclear Med)	\$50 co-pay per visit	N/A	\$50 co-pay per visit	N/A
• Intensive Care Unit services for dependents through age 17 at Valley Children's	20%	40%	10%	40%
Intensive Care Unit services for dependents through age 17 at all other hospitals	No Benefit	40%	No Benefit	40%
Lab and Imaging (at other PPO Providers)	20%	40%	10%	40%
Physician Office Visits & Urgent Care	\$15 co-pay per visit	40%	\$15 co-pay per visit	40%
Ancillary Services** during a Physician Office Visit or Urgent Care	20%	40%	10%	40%
Annual Exams - includes immunizations	\$15 co-pay per visit	40%	\$15 co-pay per visit	40%
Well Baby Care - up to age 24 months- includes immunizations	\$15 co-pay per visit	40%	\$15 co-pay per visit	40%
Baby Deliveries***				
Tier 1- In Network Hospital (excluding Community Medical Center)	\$250 co-pay	40%	\$250 co-pay	40%
Tier 2- Clovis Community and Community Regional Hospitals	20%	N/A	10%	N/A
All other Hospitalization with pre-certification	20%	40%	10%	40%
Breast Pumps- Eligible in last trimester up to 1yr after birth	20%	No Benefit	10%	No Benefit
Allergy-Testing, Injections & Serum	20%	40%	10%	40%
Hearing Aid Service	20%	40%	10%	40%
Home Health Care	20%	40%	10%	40%
Extended Care Facility	20%	40%	10%	40%
Chiropractic (\$500 per year max)	20%	40%	10%	40%
Physical Therapy	20%	40%	10%	40%
Mental Illness - Outpatient	\$15 co-pay per visit	40%	\$15 co-pay per visit	40%
Mental Illness - Inpatient	20%	40%	10%	40%
Durable Medical Equipment	20%	40%	10%	40%
Speech & Language	20%	40%	10%	40%
Infertility	50% up to a maximum of \$3,000 per lifetime – no deductible			
Accident	Hospital services for treatment as an outpatient because of surgery or for emergency care if such care is provided within 48 hours of an accident. The Plan will pay 100% up to a maximum of \$500 for any one accident.			
Prescription Drug Coverage	Retail (up to a 30-day supply)		Mail Order or CVS Retail Pharmacy (90-day supply)	
Generic	\$10 co-pay		\$20 co-pay	
Brand Formulary	20% co-pay \$25 min to \$100 max per prescription		20% co-pay \$50 min to \$200 max per prescription	
Brand Non-Formulary	30% co-pay \$40 min to \$200 max per prescription		30% co-pay \$80 min to \$400 max per prescription	

All services denoted with a percentage are paid after the deductible is met, unless indicated otherwise.

\*Ancillary charges for other services including physician fees and reading or examining X-ray results shall be subject to the deductible and coinsurance

\*\*Ancillary services include, but are not limited to, breathing treatments, throat cultures, lab work, injections, etc.

\*\*\*Baby Deliveries at Community Medical Center Hospitals do not qualify for the \$250 co pay. Co-pay only applies to deliveries and not services leading up to delivery. Physician costs (OB/GYN or anesthesiologist) apply to deductible and co-insurance.

**IN THE CASE OF ANY CONFLICTS BETWEEN THIS SUMMARY AND THE PLAN DOCUMENT, THE TERMS OF THE PLAN WILL RULE.**