Heritage

HERITAGE BENEFITS

Group Medical Insurance

MONTHLY PREMIUMS

LOW PLAN
- **$182** – Single Coverage
- **$345** – Employee + Children
- **$400** – Employee + Spouse
- **$491** – Family Coverage

HIGH PLAN
- **$139** – Single Coverage
- **$263** – Employee + Children
- **$304** – Employee + Spouse
- **$373** – Family Coverage

BASIC PLAN
- **$94** – Single Coverage
- **$179** – Employee + Children
- **$207** – Employee + Spouse
- **$254** – Family Coverage

Benefit	Low Deductible Plan	High Deductible Plan	Basic Plan
COINSURANCE* AFTER DEDUCTIBLE			
In- and Out-of-Network Deductible	$1,000/$2,000	$2,000/$4,000	$3,000/$6,000
In-Network Coinsurance	20%	20%	20%
In-Network Out-of-Pocket Maximum	$2,400/$4,000	$5,000/$10,000	$5,000/$10,000
Doctor Visits			
Office Visit	$25 copay	$25 copay	20% coinsurance
Adult Routine Physical	Covered in full	Covered in full	Covered in full
Well-Child Visits/Immunizations l	Covered in full	Covered in full	Covered in full
Specialist Office Visit	20% after deductible	20% after deductible	20% after deductible
Allergy Test and Injections	20% after deductible	20% after deductible	20% after deductible
Mental Health Care (outpatient visits)	20% after deductible	20% after deductible	20% after deductible
Chemical Dependency (outpatient visits)	20% after deductible	20% after deductible	20% after deductible
Maternity Care			
Office, Hospital, Physician, Newborn	20% after deductible	20% after deductible	20% after deductible
Urgent/Emergency Care			
Urgent/Convenience Care	$50 copay	$50 copay	20% after deductible
Emergency Room Care for Life Threatening Situations	20% after deductible	20% after deductible	20% after deductible
Emergency Care of Non Life Threatening/Non Urgent	20% after deductible	20% after deductible	20% after deductible

** Coinsurance means the percentage that the employee would pay*

Benefit	Low Deductible Plan	High Deductible Plan	Basic Plan
COINSURANCE* AFTER DEDUCTIBLE CONTINUED			
Hospital Coverage			
Ambulance	20% after deductible	20% after deductible	20% after deductible
Room & Board (unlimited days semi-private)	20% after deductible	20% after deductible	20% after deductible
Ambulatory Surgery	20% after deductible	20% after deductible	20% after deductible
Chiropractic Services & Therapy			
Office Visit	20% after deductible	20% after deductible	20% after deductible
Ancillary Charges	20% after deductible	20% after deductible	20% after deductible
Other Services			
Free Standing Laboratory	Covered in full	Covered in full	Covered in full
Laboratory	20% after deductible	20% after deductible	20% after deductible
X-Ray	20% after deductible	20% after deductible	20% after deductible
Chemo, Dialysis, Radiation	20% after deductible	20% after deductible	20% after deductible
Home Health Care	20% after deductible	20% after deductible	20% after deductible
Skilled Nursing Facility (120 days per admission/360 lifetime)	20% after deductible	20% after deductible	20% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible	20% after deductible
Vision Coverage			
Eye Exam (once every 24 months)	$25 copay	$25 copay	NA
Glasses or Contact Lenses (every 24 months)	$60 allowance	$60 allowance	NA
Prescription Drug Coverage			
In-House Pharmacy	$10 / $20 / $35	$10 / $25 / $50	$20 / $40 / $75
In-House Pharmacy (90 day supply)	$25 / $50 / $87.50	$25 / $62.50 / $12	$50 / $100 / $187.50
Retail Pharmacy	$15 / $30 / $50	$25 / $50 / $75	$40 / $75 / $100
OUT-OF-NETWORK COVERAGE			
Deductible	Same as above	Same as above	Same as above

** Coinsurance means the percentage that the employee would pay*