HERITAGE BENEFITS

Group Medical Insurance

MONTHLY PREMIUMS

HYBRID 1000
$185 – Single Coverage
$352 – Employee + Children
$408 – Employee + Spouse
$501 – Family Coverage

HYBRID 2000
$142 – Single Coverage
$269 – Employee + Children
$310 – Employee + Spouse
$381 – Family Coverage

HIGH DEDUCTIBLE 4000
$94 – Single Coverage
$179 – Employee + Children
$207 – Employee + Spouse
$255 – Family Coverage

Benefit	Hybrid 1000	Hybrid 2000	High Deductible 4000
In- and Out-of-Network Deductible	$1,000/$2,000	$2,000/$4,000	$4,000/$8,000
In-Network Coinsurance	20%	20%	10%
In-Network Out-of-Pocket Maximum	$2,400/$4,000 *(medical only)* $1,850/$3,700 *(Rx only)*	$5,000/$10,000 *(medical only)* $3,000/$6,000 *(Rx only)*	$6,000/$12,000 *(medical and Rx combined)*
Out-of-Network Coinsurance	40%	40%	20%
Out-of-Network Out-of-Pocket Maximum	$3,000/$5,000	$6,000/$12,000	$8,000/$16,000
Doctor Visits			
Office Visit	$25 copay	$25 copay	10% after deductible
Adult Routine Physical	Covered in full	Covered in full	Covered in full
Well-Child Visits/Immunizations	Covered in full	Covered in full	Covered in full
Specialist Office Visit	20% after deductible	20% after deductible	10% after deductible
Allergy Test and Injections	20% after deductible	20% after deductible	10% after deductible
Mental Health Care *(outpatient visits)*	20% after deductible	20% after deductible	10% after deductible
Chemical Dependency *(outpatient visits)*	20% after deductible	20% after deductible	10% after deductible
Maternity Care			
Office, Hospital, Physician, Newborn	20% after deductible	20% after deductible	10% after deductible
Urgent/Emergency Care			
Urgent/Convenience Care	$50 copay	$50 copay	10% after deductible
Emergency Room Care for Life Threatening Situations	20% after deductible	20% after deductible	10% after deductible
Emergency Care of Non Life Threatening/Non Urgent	20% after deductible	20% after deductible	10% after deductible
Ambulance	20% after deductible	20% after deductible	10% after deductible

Benefit	Hybrid 1000	Hybrid 2000	High Deductible 4000
COINSURANCE* AFTER DEDUCTIBLE CONTINUED			
Hospital Coverage			
Ambulance	20% after deductible	20% after deductible	10% after deductible
Room & Board *(unlimited days semi-private)*	20% after deductible	20% after deductible	10% after deductible
Ambulatory Surgery	20% after deductible	20% after deductible	10% after deductible
Chiropractic Services & Therapy			
Office Visit	20% after deductible	20% after deductible	10% after deductible
Ancillary Charges	20% after deductible	20% after deductible	10% after deductible
Other Services			
Free Standing Laboratory	Covered in full	Covered in full	Covered in full
Laboratory	20% after deductible	20% after deductible	10% after deductible
X-Ray	20% after deductible	20% after deductible	10% after deductible
Chemo, Dialysis, Radiation	20% after deductible	20% after deductible	10% after deductible
Home Health Care	20% after deductible	20% after deductible	10% after deductible
Skilled Nursing Facility *(120 days per admission/360 lifetime)*	20% after deductible	20% after deductible	10% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible	10% 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 / $120	$50 / $100 / $187.50
Retail Pharmacy	$15 / $30 / $50 *not subject to deductible*	$25 / $50 / $75 *not subject to deductible*	$40 / $75 / $100 *subject to deductible*

Deductible is the amount you pay for health care services before your health insurance begins to pay.
Coinsurance is the percentage of costs of a covered health care service you pay (10%, for example) after you've paid your deductible.
A **copay** is the flat amount of money pay for a healthcare service.