

	<h1 style="text-align: center;">Medical Plan Comparison</h1>					
	IBC PPO HSA \$4000 \$40/\$70		IBC POS 2000 30/60		IBC PPO 3000 30/60	
<i>All Full-Time Employees are eligible for benefits 1st of the month following employment.</i>	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Individual)	\$4,000.00	\$6,000.00	\$2,000.00	\$5,000.00	\$3,000.00	\$5,000.00
Deductible (Family)	\$8,000.00	\$12,000.00	\$4,000.00	\$10,000.00	\$6,000.00	\$10,000.00
Out of Pocket Max (Individual)	\$6,750.00	\$12,000.00	\$7,900.00	\$30,000.00	\$7,900.00	\$10,000.00
Out of Pocket Max (Family)	\$13,500.00	\$24,000.00	\$15,800.00	\$60,000.00	\$15,800.00	\$20,000.00
Coinsurance	Depends on Service	50% coinsurance	Depends on Service	50% coinsurance	Depends on Service	50% coinsurance
PCP Office Visit	\$40.00/Visit	50% coinsurance	\$30.00/Visit 50% coinsurance.*	50% coinsurance	\$30.00/Visit*	50% coinsurance
Specialist co-pay visit	\$70.00/Visit	50% coinsurance	\$60.00/Visit 50% coinsurance.*	50% coinsurance	\$60.00/Visit*	50% coinsurance
Preventive Care	No Charge.*	50% coinsurance.*	No Charge. 50% coinsurance.*	50% coinsurance.*	No Charge.*	50% coinsurance.
Diagnostic Testing (CT/PET scans, MRIs)	\$300.00/Scan	50% coinsurance	\$200.00/Scan*	50% coinsurance	\$200.00/Scan	50% coinsurance
X-Ray	\$70.00/Visit	50% coinsurance	\$60.00/Visit*	50% coinsurance	\$60.00/Visit*	50% coinsurance
Blood Work	\$70.00/Visit	50% coinsurance	\$60.00/Visit*	50% coinsurance	\$60.00/Visit	50% coinsurance
Freestanding Facilities	\$140.00/Visit Hospital-based facilities	50% coinsurance	N/A	N/A	\$120.00/Visit Hospital-based facilities	50% coinsurance
Urgent Care	\$100.00/Visit	50% coinsurance	\$100.00/Visit*	50% coinsurance	\$100.00/Visit*	50% coinsurance
Emergency Room	\$300.00/Visit	Covered at In-Network level	\$300.00/Visit	Covered at In-Network level	\$300.00/Visit	Covered at In-Network level
Ambulance	No Charge.	Covered at In-Network level	\$200.00/Transport*	Covered at In-Network level	\$150.00/Transport*	Covered at In-Network level
In-Patient Hospital	\$250.00/Day Max of 5 Copayment(s)/Admission	50% coinsurance	20% Coinsurance	50% coinsurance	10% coinsurance	50% coinsurance
Out-Patient	\$70.00/Visit	50% coinsurance	\$60.00/Visit*	50% coinsurance	\$60.00/Visit*	50% coinsurance
RX Tier 1	(1-30 days supply) \$20.00/Fill (31-90 days supply) \$40.00/Fill	Not covered. Retail (1-30 days supply) 50% reimbursement	(1-30 days supply) \$20.00/Fill (31-90 days supply) \$40.00/Fill*	Not covered. Retail (1-30 days supply) 30% reimbursement*	(1-30 days supply) \$20.00/Fill (31-90 days supply) \$40.00/Fill*	Not covered. Retail (1-30 days supply) 30% reimbursement*
RX Tier 2	(1-30 days supply) \$40.00/Fill (31-90 days supply) \$80.00/Fill	Not covered. Retail (1-30 days supply) 50% reimbursement	(1-30 days supply) \$40.00/Fill (31-90 days supply) \$80.00/Fill	Not covered. Retail (1-30 days supply) 30% reimbursement*	(1-30 days supply) \$40.00/Fill (31-90 days supply) \$80.00/Fill*	Not covered. Retail (1-30 days supply) 30% reimbursement*
RX Tier 3	(1-30 days supply) \$70.00/Fill (31-90 days supply) \$140.00/Fill	Not covered. Retail (1-30 days supply) 50% reimbursement	(1-30 days supply) \$70.00/Fill (31-90 days supply) \$140.00/Fill	Not covered. Retail (1-30 days supply) 30% reimbursement*	(1-30 days supply) \$70.00/Fill (31-90 days supply) \$140.00/Fill*	Not covered. Retail (1-30 days supply) 30% reimbursement*
RX Tier 4	(1-30 days supply) 50% coinsurance (\$500.00 max/fill)	Not covered	(1-30 days supply) 50% coinsurance (\$1,000.00 max/fill)*	Not covered	(1-30 days supply) 50% coinsurance (\$1,000.00 max/fill)*	Not covered

Check the individual SBC's for a more detailed review of each plan  
Deductible does not apply\*

Tier	Employee Monthly Cost	Employee Cost Per Pay	Employee Monthly Cost	Employee Cost Per Pay	Employee Monthly Cost	Employee Cost Per Pay
EE	\$115.91	\$57.95	\$191.14	\$95.57	\$215.10	\$107.55
EE+Spouse	\$266.58	\$133.29	\$439.61	\$219.81	\$494.72	\$247.36
EE+Children	\$206.31	\$103.16	\$340.22	\$170.11	\$382.87	\$191.44
Family	\$339.60	\$169.80	\$560.03	\$280.01	\$630.23	\$315.12



# Davis Vision Plan

Vision Care 150		
	In-Network	Out-of-Network
Eye Exam (1 exam/year)	\$10	\$40 Reimbursement
<b>Lenses:</b>	(1 pair/year)	
Single Vision Lenses	\$25	\$40 Reimbursement
Bifocal Lenses	\$25	\$60 Reimbursement
Trifocal Lenses	\$25	\$80 Reimbursement
Lenticular Lenses	\$25	\$100 Reimbursement
<b>Frames:</b>	(1 pair/Every 24 Months)	
Davis Collection	No charge	Not covered
Non-Collection Frames	Up to \$150 Allowance (plus a 20% discount on overage)	\$50 Reimbursement
Visionworks Frames Option	Up to \$200 Allowance (plus a 20% discount on overage)	Not covered
<b>Contact Lenses (in lieu of glasses)</b>	(1 pair/year)	
Davis Collection Contact Lenses	8 Boxes/Year	Not covered
Non-Collection Contact Lenses	Up to \$150 Allowance	\$105 Reimbursement