SCHOOL ADMINISTRATORS' WELFARE TRUST MEDICAL PLAN OPTIONS
BENEFIT HIGHLIGHTS

PLAN BENEFITS	PPO Plan		HMO Plan
	In-Network	Out-of-Network	
Deductible Per Member	$500	$1,000	None
Deductible Per Family	$1,000	$2,000	None
Coinsurance	20% of EME	50% of EME[1]	None
Coinsurance Maximum	$2,500/Member $5,000/Family	$7,000/Member[1] $14,000/Family[1]	$6,850/Member, $13,700/Family
Doctor Office Visit Copayment	$25/Visit	After CYD, Member pays 50% of EME[1]	$20/Visit
Specialist Office Visit Copayment	$40/Visit	After CYD, Member pays 50% of EME[1]	$40/Visit
Inpatient/Outpatient Hospital Facility	After CYD, Member pays 20% of EME	After CYD, Member pays 50% of EME[1]	$500/Admission
Ambulatory Surgical Facility	After CYD, Member pays 20% of EME	After CYD, Member pays 50% of EME[1]	$100/Surgery
Inpatient Hospital Facility Surgical Services	After CYD, Member pays 20% of EME	After CYD, Member pays 50% of EME[1]	$100/Surgery
Outpatient Hospital Facility Surgical Services	After CYD, Member pays 20% of EME	After CYD, Member pays 50% of EME[1]	$100/Surgery
Physician's Office Surgical Services	After CYD, Member pays 20% of EME	After CYD, Member pays 50% of EME[1]	$20/Visit
Specialist's Office Surgical Services	After CYD, Member pays 20% of EME	After CYD, Member pays 50% of EME[1]	$40/Visit
Anesthesia	After CYD, Member pays 20% of EME	After CYD, Member pays 50% of EME[1]	$150/Surgery
Urgent Care Within Service Area	$25/Visit	$25/Visit[1]	$35/Visit
Urgent Care Outside Service Area	$25/Visit	$25/Visit[1]	$35/Visit[1]
Ambulance Services	$300/Trip	After CYD, Member pays 50% of EME[1]	$500/Trip
Emergency Room	$300/Visit, Waived if Admitted		$500/Visit, Waived if Admitted
Laboratory Services	$15/Visit	After CYD, Member pays 50% of EME[1]	$10/Visit
Routine Radiological Services	$35/Visit	After CYD, Member pays 50% of EME[1]	$20/Visit
Hearing Aids	After CYD, Member pays 20% of EME[2]	After CYD, Member pays 50% of EME[1 & 2]	$0[2]
Prescriptions 30 Day Therapeutic Supply	• Tier I - $10 Copay • Tier II - $35 Copay • Tier III - $60 Copay * Generic Mandate (if Generic is Available) * Step Therapy Requirement * Includes Formulary Exclusions * Mail Order = 2 Copay for a 90 Day Supply (All Tiers)		• Tier I - $15 Copay • Tier II - $40 Copay • Tier III - $60 Copay * Generic Mandate (if Generic is Available) * Step Therapy Requirement * Includes Formulary Exclusions * Mail Order = 2 Copay for a 90 Day Supply (All Tiers)

[1]Note: You are responsible for all amounts exceeding the applicable EME payments to Non-PPO Providers. Further, such amounts do not accumulate to your Coinsurance Maximum.

[2]Purchases are limited to a single purchase of a type of hearing aid, including repair and replacement, once every three (3) years.

CYD = Calendar Year Deductible CY = Calendar Year EME = Eligible Medical Expense (the maximum amount that the insurance carrier will pay for a particular covered service)

9/28/16 NV