J.B. Coxwell Contracting, Inc.
Medical Benefit Summary
Benefits Effective January 1, 2014

Benefits ***In-Network***	**AETNA HNO 07 10** ***In-Network***	**AETNA HNO 04 10** ***In-Network***	**AETNA OA MC 02 10** ***In-Network***
Deductible	**$3,000 Ind / $6,000 Family**	**$2,000 Ind / $4,000 Family**	**$1,500 Ind / $3,000 Family**
Co-insurance	**70%**	**80%**	**80%**
Out-of-Pocket Maximum	**$5,000 Ind / $10,000 Family**	**$5,000 Ind / $10,000 Family**	**$3,500 Ind / $7,000 Family**
	(Includes Deductible, Copayments & Coinsurance, Excludes Rx Copayments)		***(Excludes Deductible and Copayments)***
Lifetime Maximum	**Unlimited**	**Unlimited**	**Unlimited**
Preventive Services	**100% (not subject to deductible)**	**100% (not subject to deductible)**	**100% (not subject to deductible)**
Primary Care Physician	**$50 Copay** (not subject to deductible)	**$40 Copay** (not subject to deductible)	**$30 Copay** (not subject to deductible)
Specialist	**$70 Copay** (not subject to deductible)	**$60Copay** (not subject to deductible)	**$50 Copay** (not subject to deductible)
Urgent Care	**$75 Copay** (not subject to deductible)	**$75 Copay** (not subject to deductible)	**$75 Copay** (not subject to deductible)
Emergency Room	**$200 Copay** (not subject to deductible)	**$200 Copay** (not subject to deductible)	**$200 Copay** (not subject to deductible)
Inpatient Hospital	**30% after Deductible**	**20% after Deductible**	**20% after Deductible**
Outpatient Surgery	**30% after Deductible**	**20% after Deductible**	**20% after Deductible**
Basic Lab/X-ray	**30% after Deductible**	**20% after Deductible**	**20% after Deductible**
Outpatient Major Lab / X-Ray	**30% after Deductible**	**20% after Deductible**	**20% after Deductible**
Vision Exam (Once every 24 months)	**Covered at 100%** (deductible and coinsurance waived)	**Covered at 100%** (deductible and coinsurance waived)	**$50 Copay (not subject to deductible)**
Mental/Nervous Outpatient	**$70 Copay (not subject to deductible)**	**$60 Copay (not subject to deductible)**	**$50 Copay (not subject to deductible)**
Prescriptions *(Participating Pharmacies)*	**$20 Tier 1** **$40 Tier 2** **$70 Tier 3** **Mail Order: 2 x copay**	**$15 Tier 1** **$35 Tier 2** **$60 Tier 3** **Mail Order: 2 x copay**	**$10 Tier 1** **$30 Tier 2** **$50 Tier 3** **Mail Order: 2 x copay**
Benefits Out of Network			***Out-of-Network***
Deductible	**N/A**	**N/A**	**$3,000 Ind / $6,000 Family**
Co-insurance	**N/A**	**N/A**	**50%**
Out-of-Pocket Maximum	**N/A**	**N/A**	**$10,000 Ind / $20,000 Family**
Prescriptions	**N/A**	**N/A**	**30% of submitted cost after the applicable in-network copay**
Monthly Rates			
EE	415	458	571
ES	877	957	1194
EC	789	870	1085
FAM	1324	1461	1822