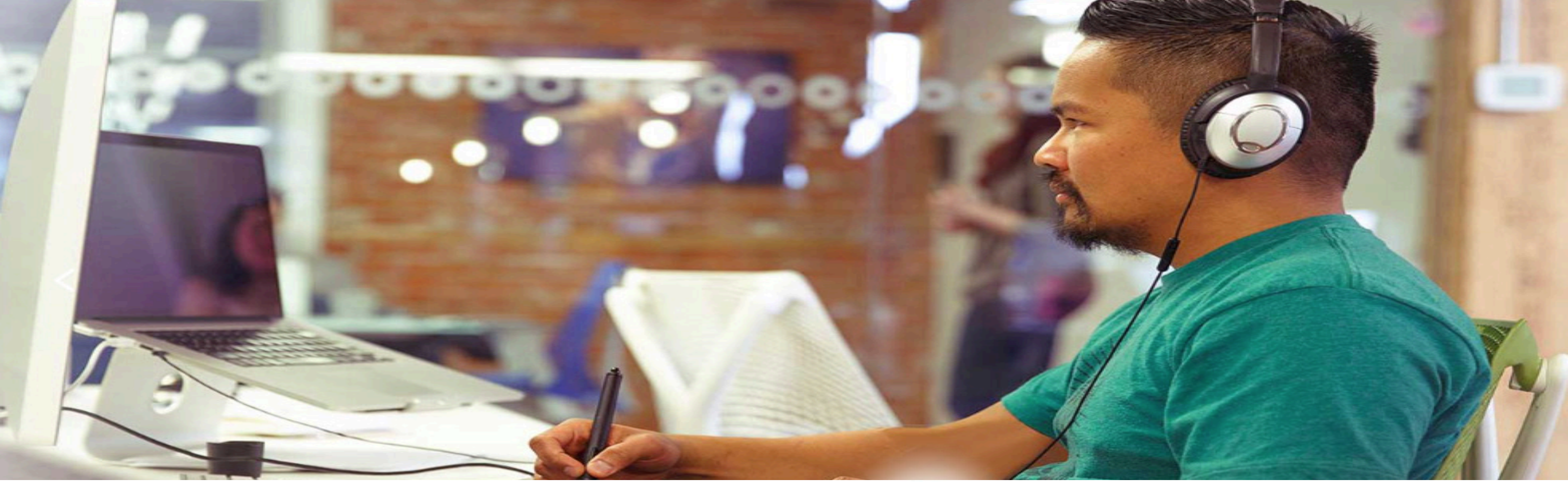
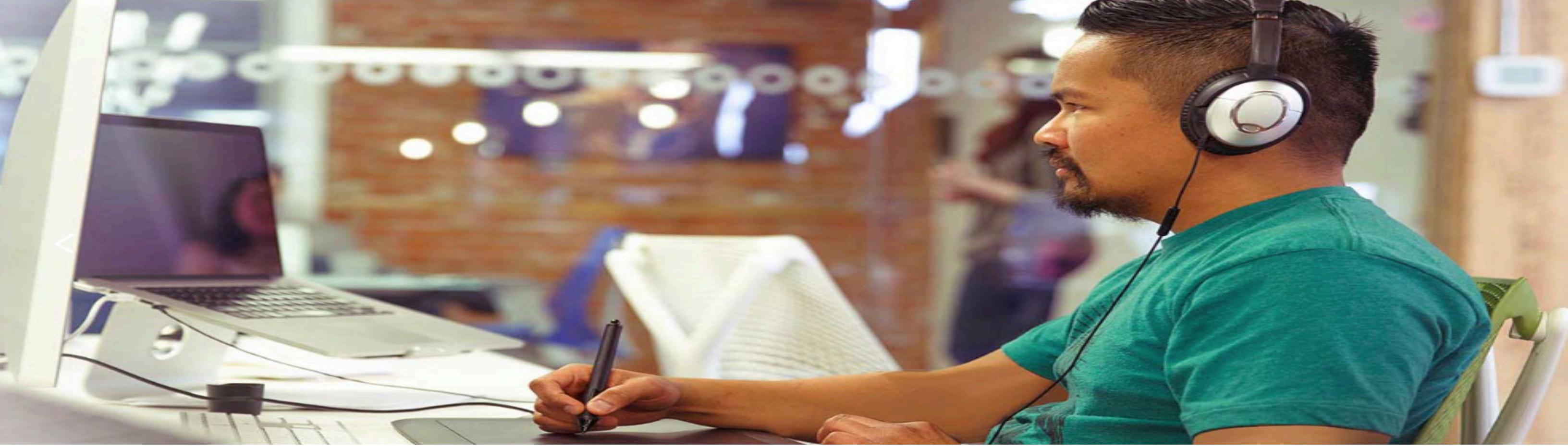


Employee Benefits At A Glance – 2017

Medical – Humana	$1,000 80/60 NPOS 10 Copay $25/$55		$1,500 80/60 NPOS 10 Copay $25/$55		$3,000 100/70 NPOS 10 Copay $25/$55	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Co-Insurance (You pay)	80%	60%	80%	60%	100%	70%
Calendar Year Deductible - Individual - Family	 $1,000 $2,000	 $3,000 $6,000	 $1,500 $3,000	 $4,500 $9,000	 $3,000 $6,000	 $9,000 $18,000
Out-of-Pocket Maximum (Deductible included) - Individual - Family	 $3,000 $6,000	 $9,000 $18,000	 $4,500 $9,000	 $13,500 $27,000	 $3,000 $6,000	 $18,000 $36,000
Office Visit Copay - Primary - Specialist	 $25 Copay $55 Copay	 30% After deductible 30% After deductible	 $25 Copay $55 Copay	 30% After deductible 30% After deductible	 $25 Copay $55 Copay	 30% After deductible 30% After deductible
Preventive Visits						
Inpatient Services	20% After deductible	40% After deductible	20% After deductible	40% After deductible	Deductible	30% After deductible
Outpatient Services	20% After deductible	40% After deductible	20% After deductible	40% After deductible	Deductible	30% After deductible
Emergency Room Services (Waived if admitted)	$250 Copay	$250 Copay	$250 Copay	$250 Copay	$250 Copay	$250 Copay
Urgent Care	$75 Copay	30% After deductible	$75 Copay	30% After deductible	$75 Copay	30% After deductible
Lifetime Max. Benefits	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Prescription Coverage (30 day supply)	**$1,000 80/60 NPOS 10 Copay $25/$55**		**$1,500 80/60 NPOS 10 Copay $25/$55**		**$3,000 100/70 NPOS 10 Copay $25/$55**	
Deductible Tier 1 Tier 2 Tier 3 Tier 4 Tier 5	$0 $10 Copay $35 Copay $55 Copay 25% Coinsurance 35% Coinsurance		$0 $10 Copay $40 Copay $65 Copay 25% Coinsurance 35% Coinsurance		$250 Individual $10 Copay (deductible waived) $45 Copay after Rx deductible $70 Copay after Rx deductible 25% After Rx deductible 35% After Rx deductible	
Mail Order Maintenance (90 day supply)						
Mail-Order Tier 1 Mail-Order Tier 2 Mail-Order Tier 3 Mail-Order Tier 4 Mail-Order Tier 5	$15 Copay $87.50 $165 Copay 25% Coinsurance 35% Coinsurance		$15 Copay $100 Copay $195 Copay 25% Coinsurance 35% Coinsurance		$15 Copay (deductible waived) $112.50 Copay after Rx deductible $210 Copay after Rx deductible 25% Copay after Rx deductible 35% Copay after Rx deductible	
Employee Rates (Per pay period)						
Employee	$143.55		$121.12		$107.43	
Employee + Spouse	$394.53		$349.67		$322.27	
Employee + Child(ren)	$356.88		$315.39		$290.04	
Family	$607.86		$543.94		$504.90	



Dental Plan BCBS	Classic Complete GA-2Q (1R1M)	
	In-Network	Out-of-Network
Annual Deductible Individual Family	 $50 $150	 $100 $300
Preventative Services (X-rays, routine exams, cleanings)	100%	80%
Basic Services (Fillings, basic oral surgery)	80%	60%
Major Services (Crowns, periodontics, endodontics, dentures)	50%	50%
Annual Plan Maximum	$1,500	$1,500
Employee Rates	**Per pay period**	
Employee	**$8.13**	
Employee + Spouse	**$25.05**	
Employee + Child(ren)	**$28.65**	
Family	**$47.77**	

Vision Plan Humana	$20 Exam / $20 Materials 12/12/24	
	In-Network	Out-of-Network
Exams	$20 Copay	$40 Allowance
Eyeglasses Single Vision Bifocal Trifocal Lenticular	 $20 Copay $20 Copay $20 Copay $20 Copay	 $40 Allowance $60 Allowance $80 Allowance N/A
Frames	$40 Allowance (wholesale)	$57 Allowance
Contact Lenses Conventional/Disposable Medically Necessary	 $150 Allowance Covered 100%	 $150 Allowance $280 Allowance
Frequency of Services (Once per calendar year) Exam Lenses Frames Contact Lenses	 12 Months 12 Months 24 Months 12 Months	
Laser Vision Correction Discounts Available @ Participating Locations Only		
Employee Rates	**Per pay period**	
Employee	$4.00	
Employee + Spouse	$8.00	
Employee + Child(ren)	$7.60	
Family	$11.94	

Contacts & Information
Providence Insurance Group

Charles Hagan
Team Leader
ph: 770.973.9990 ext. 250
toll free: 888.224.3646
E-mail: charles@pg-ins.com

Maddy Stinehour
Customer Service
ph: 770.973.9990 ext. 243
toll free: 888.224.3646
E-mail: maddy@pg-ins.com

Medical and Vision | Humana
Member Services: 1.800.448.6262
www.humana.com

Dental | BCBS
Member Services: 1.855.397.9267
www.bcbsga.com

Please Note: This document is intended as a convenient summary of the major points of benefit plans. This document does not cover all provisions, limitations and exclusions. The official plan documents, policies and certificates of insurance govern in all cases and are available for your inspection at any time.