



Effective Jan. 1, 2018

Medical Plan Design Summary

Percentages shown indicate patient payment amount

	CLASSIC CARE PLAN		SAVINGS ADVANTAGE PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFIT PROVISIONS				
Annual Deductible	\$400/person; \$1,200/Family	\$1,000/person; \$3,000/Family	\$2,000/EE Only; \$4,000/EE+Sp/Ch; \$6,000/EE + Family (per person deductible does not apply)	\$3,300/EE Only; \$4,950/EE + Sp/Ch; \$6,600/EE + Family
Out-of-Pocket Maximum - Person	\$5,500/person	\$10,000/person	\$5,000/EE Only	\$6,350/EE Only
Out-of-Pocket Maximum - Coverage Tier Includes deductible, copays and coinsurance	\$11,000/EE+Sp/Ch; \$11,000/EE+Family	\$20,000/EE+Sp/Ch; \$20,000/EE+Family	\$7,500/EE+Sp/Ch; \$10,000/EE+Family	\$9,525/EE+Sp/Ch; \$12,700/EE+Family
PROFESSIONAL SERVICES				
Physician's Office Visit	\$25 copay*	50% after deductible	20% after deductible	40% after deductible
Specialist Office Visit	\$40 copay*			
Urgent Care Visit				
Inpatient Pre-Certification / Penalty Applies to all inpatient services including hospitals, skilled nursing facilities, hospice and mental/nervous and chemical dependency stays	Provider responsible; no penalty	Member responsible; \$250 penalty	Provider responsible; no penalty	Member responsible; \$250 penalty
TYPE OF SERVICE				
Acupuncture 12 visits per calendar year maximum	\$40 copay*	50% after deductible	20% after deductible	40% after deductible
Allergy Testing Office visit	\$25 physician visit copay* or \$40 specialist copay*			
Allergy Treatment	30% after deductible			
Ambulance Must be medically necessary				
Diagnostic X-ray and Lab Outpatient hospital or facility				
Durable Medical Equipment (DME)				
Emergency Room No coverage for non-emergency use	30% after deductible; \$125 copay per visit		20% after deductible	
Home Health Care 120 visits per year max	30% after deductible	50% after deductible	20% after deductible	40% after deductible
Hospice Care Inpatient and outpatient				
Hospital Inpatient Includes room & board, physician expenses, prescription drugs and all other inpatient care				
Per Inpatient Admission Does not apply to Hospice, SNF or other facilities	\$400 copay/stay 30% after deductible	\$1,000 copay/stay 50% after deductible		
Per Inpatient Admission Copay Limit	\$1,200/individual/year	\$3,000/individual/year		
Hospital Outpatient/Surgery Includes outpatient services performed in a hospital, ambulatory surgical center or a doctor's office, including physician's charges	30% after deductible	50% after deductible		
Radiologists, Anesthesiologists & Pathologists				
Short Term Rehabilitation Outpatient physical, speech & occupational therapy	\$40 copay*			
Skilled Nursing/Convalescent Facility 100 days per individual per year maximum	30% after deductible			
Spinal Disorders/Chiropractic Therapies 20 visits per individual per year maximum	\$40 copay*			
MENTAL/NERVOUS DISORDERS/CHEMICAL DEPENDENCY				
Inpatient Mental/Nervous Disorders and Chemical Dependency	30% after deductible	50% after deductible	20% after deductible	40% after deductible
Per Inpatient Admission	\$400/stay 30% after deductible	\$1,000/stay 50% after deductible		
Per Inpatient Admission Copay Limit	\$1,200/individual/year	\$3,000/individual/year		
Outpatient Mental/Nervous Disorders and Chemical Dependency	\$25 copay*	50% after deductible		
ROUTINE/PREVENTIVE CARE				
Preventive Care Subject to age and frequency limitations	No charge	No charge up to allowed amount*	No charge	No charge up to allowed amount*
FAMILY PLANNING				
Contraceptive Devices, Implants & Injectables Certain contraceptive devices may be covered at 100% with no copay or deductible	30% after deductible	50% after deductible	20% after deductible	40% after deductible
Maternity				
PRESCRIPTION DRUGS				
Retail Pharmacy 30 day supply		No Coverage	20% after deductible (deductible waived for certain preventive drugs)	No Coverage
Generic	\$15			
Brand-Formulary	20% (\$25 min/\$90 max)			
Brand-Non Formulary	40% (\$60 min/\$150 max)			
Mail Order or Retail Pharmacy 31-90 day supply				
Generic	\$37.50			
Brand-Formulary	20% (\$62.50 min/\$225 max)			
Brand-Non Formulary	40% (\$150 min/\$375 max)			

*Deductible waived