



Effective Jan. 1, 2019

# 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			
<b>BENEFIT PROVISIONS</b>							
<b>Annual Deductible</b>	\$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			
<b>Out-of-Pocket Maximum - Person</b>	\$5,500/person	\$10,000/person	\$5,000/EE Only	\$6,350/EE Only			
<b>Out-of-Pocket Maximum - Coverage Tier</b> 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			
<b>PROFESSIONAL SERVICES</b>							
<b>Physician's Office Visit</b>	\$25 copay*	50% after deductible	20% after deductible	40% after deductible			
<b>Specialist Office Visit</b>	\$40 copay*						
<b>Urgent Care Visit</b>							
<b>Inpatient Pre-Certification / Penalty</b> 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			
<b>TYPE OF SERVICE</b>							
<b>Acupuncture</b> 12 visits per calendar year maximum	\$40 copay*	50% after deductible	20% after deductible	40% after deductible			
<b>Allergy Testing</b> Office visit	\$25 physician visit copay* or \$40 specialist copay*						
<b>Allergy Treatment</b>	30% after deductible						
<b>Ambulance</b> Must be medically necessary							
<b>Diagnostic X-ray and Lab</b> Outpatient hospital or facility							
<b>Durable Medical Equipment (DME)</b>							
<b>Emergency Room</b> No coverage for non-emergency use	30% after deductible; \$125 copay per visit					20% after deductible	
<b>Home Health Care</b> 120 visits per year max	30% after deductible				50% after deductible	20% after deductible	40% after deductible
<b>Hospice Care</b> Inpatient and outpatient							
<b>Hospital Inpatient</b> Includes room & board, physician expenses, prescription drugs and all other inpatient care							
<b>Per Inpatient Admission</b> Does not apply to Hospice, SNF or other facilities	\$400 copay/stay 30% after deductible	\$1,000 copay/stay 50% after deductible					
<b>Per Inpatient Admission Copay Limit</b>	\$1,200/individual/year	\$3,000/individual/year					
<b>Hospital Outpatient/Surgery</b> 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					
<b>Radiologists, Anesthesiologists &amp; Pathologists</b>							
<b>Short Term Rehabilitation</b> Outpatient physical, speech & occupational therapy	\$40 copay*						
<b>Skilled Nursing/Convalescent Facility</b> 100 days per individual per year maximum	30% after deductible						
<b>Spinal Disorders/Chiropractic Therapies</b> 20 visits per individual per year maximum	\$40 copay*						
<b>MENTAL/NERVOUS DISORDERS/CHEMICAL DEPENDENCY</b>							
<b>Inpatient Mental/Nervous Disorders and Chemical Dependency</b>	30% after deductible	50% after deductible	20% after deductible	40% after deductible			
<b>Per Inpatient Admission</b>	\$400/stay 30% after deductible	\$1,000/stay 50% after deductible					
<b>Per Inpatient Admission Copay Limit</b>	\$1,200/individual/year	\$3,000/individual/year					
<b>Outpatient Mental/Nervous Disorders and Chemical Dependency</b>	\$25 copay*	50% after deductible					
<b>ROUTINE/PREVENTIVE CARE</b>							
<b>Preventive Care</b> Subject to age and frequency limitations	No charge	No charge up to allowed amount*	No charge	No charge up to allowed amount*			
<b>FAMILY PLANNING</b>							
<b>Contraceptive Devices, Implants &amp; Injectables</b> 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			
<b>Maternity</b>							
<b>PRESCRIPTION DRUGS</b>							
<b>Retail Pharmacy</b> 30 day supply		No Coverage	20% after deductible (deductible waived for certain preventive drugs)	No Coverage			
<b>Generic</b>	\$15						
<b>Brand-Formulary</b>	20% (\$25 min/\$90 max)						
<b>Brand-Non Formulary</b>	40% (\$60 min/\$150 max)						
<b>Mail Order or Retail Pharmacy</b> 31-90 day supply							
<b>Generic</b>	\$37.50						
<b>Brand-Formulary</b>	20% (\$62.50 min/\$225 max)						
<b>Brand-Non Formulary</b>	40% (\$150 min/\$375 max)						

\*Deductible waived