SET SEG
School Insurance Specialists

Medical Rate Summary
Escanaba Area Schools
All Employees

Assumed Effective Date: 7/1/2015

Current Plan(s) and Segment:	1P	2P	FF	Total Monthly Cost
Administration	0	3	6	
MESSA $500-0%; Saver Rx	$517.61	$1,162.75	$1,446.61	$12,167.91
Non-Union Staff	1	1	2	
MESSA $500-0%; Saver Rx	$517.61	$1,162.75	$1,446.61	$4,573.58
Non-Union Secretaries	0	0	1	
MESSA $500-0%; Saver Rx	$517.61	$1,162.75	$1,446.61	$1,446.61
Teachers	10	20	60	
MESSA $500-0%; Saver Rx	$516.11	$1,161.25	$1,445.11	$115,092.70
Support - Teamsters	8	8	10	
MESSA $500-0%; Saver Rx	$517.61	$1,162.75	$1,446.61	$27,908.98
Support - MESPA	28	0	0	
MESSA $500-0%; Saver Rx	$528.15	$1,186.46	$1,476.11	$14,788.20

Total Monthly Cost $175,977.98
Total Annual Cost $2,111,735.76

Quoted Plans	1P	2P	FF	Total Monthly Cost
	47	32	79	
Consumers Mutual PPO $500-0%; $10/$40/$80/20% Rx	Rate $659.00	$1,482.75	$1,845.20	$224,191.80
Consumers Mutual PPO $500-0%; $2000/$4000 OOP; $10/$40/$80/20% Rx	Rate $645.82	$1,453.10	$1,808.30	$219,708.44

Notes:

Rates do not include SET SEG's $7.00 pepm fee for billing and enrollment services.

Proposed rates are based on census provided by the district. Rates may change based on actual group enrollment and participation.

Consumers Mutual:

Consumers Mutual proposed rates include estimated taxes or fees associated with the Affordable Care Act.

Health Plan Options

Offered By: SET SEG School Insurance Specialists

Escanaba Area Schools

Consumers Mutual PPO $500-0%; $2000/$4000 OOP; $10/$40/$80/20% Rx

Conventional PPO Plan

	All Employees		
	1P	2P	FF
Monthly Premium	$645.82	$1,453.10	$1,808.30
Proposed Monthly Cost		$219,708.44	
Proposed Annual Cost		**$2,636,501.28**	
Total Annual Savings - $		-$524,765.52	
Total Annual Savings - %		24.8%	
PA 152 Cap (2015)	$499.36	$1,044.31	$1,361.89
Employee Cost Share w/cap	$146.46	$408.79	$446.41

ABOUT THE PLAN

Description: Traditional - Traditional insurance with deductibles and copays
Network: Conventional PPO Plan
Effective Date: 7/1/2015

BEFORE DEDUCTIBLE IS MET, PATIENT PAYS...

Deductible: $500/$1000
Coinsurance: 0% coinsurance after deductible has been met
OV/Specialist: $20 office visit copay and $35 specialist visit copay
Urgent Care/ER: $50 urgent care copay and $150 emergency room copay
Chiropractic: $35 copay for visits, 30 visit max per year (combined with PT and OT)
Prescription Drugs: $10/$40/$80/20%

AFTER DEDUCTIBLE IS MET, PATIENT PAYS...

Deductible: N/A
Coinsurance: 0% coinsurance
OV/Specialist: $20 office visit copay and $35 specialist visit copay until Out of Pocket Max is reached
Urgent Care/ER: $50 urgent care copay and $150 emergency room copay until Out of Pocket Max is reached
Chiropractic: $35 copay for visits until Out of Pocket Max is reached, 30 visit max per year (combined with PT and OT)
Prescription Drugs: $10/$40/$80/20% until Out of Pocket Max is reached

$2,000/$4,000 OUT-OF-POCKET MAXIMUM INCLUDES DEDUCTIBLE, COINSURANCE AND COPAYS
AFTER OUT-OF-POCKET MAXIMUM IS MET, PLAN PAYS 100% OF COVERED SERVICES

***Please see Rate Summary page for important notes pertaining to this quote.**

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Health Plan Options

Offered By: SET SEG School Insurance Specialists

Escanaba Area Schools

Consumers Mutual PPO $500-0%, $10/$40/$80/20% Rx
Conventional PPO Plan

	All Employees		
	1P	2P	FF
Monthly Premium	$659.00	$1,482.75	$1,845.20
Proposed Monthly Cost		$224,191.80	
Proposed Annual Cost		**$2,690,301.60**	
Total Annual Savings - $		-$578,565.84	
Total Annual Savings - %		-27.4%	
PA 152 Cap (2015)	$499.36	$1,044.31	$1,361.89
Employee Cost Share w/cap	$159.64	$438.44	$483.31

ABOUT THE PLAN

Description:	Traditional - Traditional insurance with deductibles and copays
Network:	Conventional PPO Plan
Effective Date:	7/1/2015

BEFORE DEDUCTIBLE IS MET, PATIENT PAYS...

Deductible:	$500/$1000
Coinsurance:	0% coinsurance after deductible has been met
OV/Specialist:	$20 office visit copay and $35 specialist visit copay
Urgent Care/ER:	$50 urgent care copay and $150 emergency room copay
Chiropractic:	$35 copay for visits, 30 visit max per year (combined with PT and OT)
Prescription Drugs:	$10/$40/$80/20%

AFTER DEDUCTIBLE IS MET, PATIENT PAYS...

Deductible:	N/A
Coinsurance:	0% coinsurance
OV/Specialist:	$20 office visit copay and $35 specialist visit copay until Out of Pocket Max is reached
Urgent Care/ER:	$50 urgent care copay and $150 emergency room copay until Out of Pocket Max is reached
Chiropractic:	$35 copay for visits until Out of Pocket Max is reached, 30 visit max per year (combined with PT and OT)
Prescription Drugs:	$10/$40/$80/20% until Out of Pocket Max is reached

$1,000/$2,000 OUT-OF-POCKET MAXIMUM INCLUDES DEDUCTIBLE, COINSURANCE AND COPAYS
AFTER OUT-OF-POCKET MAXIMUM IS MET, PLAN PAYS 100% OF COVERED SERVICES

***Please see Rate Summary page for important notes pertaining to this quote.**

Schedule of Copayments and Deductibles

Deductibles

Type	In Network Benefit	Out of Network Benefit
Individual	$500 per calendar year	$1,000 per covered person per calendar year
Family	$1,000 per family per calendar year	$2,000 per family per calendar year

- Out of Network deductibles are separate from In Network deductibles.
- Deductibles apply toward out-of-pocket maximums.

Individual Coinsurance

In Network Benefit	Out of Network Benefit
100%	70%

- The plan pays the above percentages of eligible charges, unless otherwise stated, after the deductible is satisfied.
- The plan pays 100% for the remainder of the calendar year *after* the out-of-pocket maximum has been reached.

Out-of-pocket Maximums

Type	In Network Benefit	Out of Network Benefit
Individual Maximum	$1,000 per covered person per calendar year	$2,500 per covered person per calendar year
Family Maximum	$2,000 per family per calendar year	$5,000 per family per calendar year

- Out of Network out-of-pocket maximums are separate from In Network out-of-pocket maximums.
- Deductibles, copayments and coinsurances apply toward out-of-pocket maximums.

Physician Office Services and Urgent and Emergency Care Services

Service	In Network Benefit	Out of Network Benefit	Limitations
Primary Care Physician's Office Visit.	$20 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Coverage includes labs, x-rays, injections, and medical supplies rendered in the office on the same day. Does not include MRI's, CT and PET scans.
Specialist Physician's Office Visit	$35 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	
Urgent Care Visit	$50 copay, then paid 100% not subject to the deductible	$50 copay, then paid 100% not subject to the deductible	Must be medically necessary.
Emergency Room	$150 copay, then paid at 100% not subject to the deductible	$150 copay, then paid at 100% not subject to the deductible	ER per visit copay waived if admitted. Out-of-Network benefit services are subject to the In-Network benefit out of pocket.
Land/Air Ambulance	100% subject to the deductible	70% subject to the deductible	Not applicable.
Office Surgery	100% subject to the deductible	70% subject to the deductible	Not applicable.

Hospital and Surgical Services (including newborn hospital care)

Service	In Network Benefit	Out of Network Benefit	Limitations
Room and Board	100% subject to the deductible	70% subject to the deductible	Based on the semi-private room rate. Charges for routine newborn care are covered under the mother for up to 5 days.
Miscellaneous Charges	100% subject to the deductible	70% subject to the deductible	Excludes patient convenience items.
Inpatient Surgery	100% subject to the deductible	70% subject to the deductible	Not applicable.
Assistant Surgeons	Charges are limited to a maximum benefit of 25% of the surgeon's allowable amount.		
Office/ Outpatient Surgery	100% subject to the deductible	70% subject to the deductible	Not applicable.
Inpatient Physician Hospital Visits	100% subject to the deductible	70% subject to the deductible	Not applicable.

Diagnostic and Preventive Services

Service	In Network Benefit	Out of Network Benefit	Limitations
Preventive & Wellness	100% not subject to the deductible	70% subject to the deductible	Routine services not part of the Patient Protection & Affordable Care Act listed below will be payable as any other illness.
Office Visit Medical Supplies	100%	70% subject to the deductible	Office copay applies if no office exam billed.
Lab and X-ray: in office	100%	70% subject to the deductible	Office copay applies if no office exam billed.
Lab: non-office facility	$20 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Includes services rendered outpatient hospital.
X-ray: non-office facility	$20 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Includes services rendered outpatient hospital.
X-ray: MRI/CT scan/PET scan	$150 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Prior approval is required.
In-office Medical & Allergy Injections	100%	70% subject to the deductible	Office copay applies if office exam billed.

Other Covered Services

Service	In Network Benefit	Out of Network Benefit	Limitations
Durable Medical Equipment	100% subject to the deductible	70% subject to the deductible	Not applicable.
Home Health Care	100% subject to the deductible	70% subject to the deductible	Not applicable.
Hospice Care	100% subject to the deductible	70% subject to the deductible	Prior approval required for charges received after 6 months.

Service	In Network Benefit	Out of Network Benefit	Limitations
Prosthetics	100% subject to the deductible	70% subject to the deductible	Not applicable.
Skilled Nursing Services	100% subject to the deductible	70% subject to the deductible	Limited to 45 days per calendar year.
Infertility Services	100% subject to the deductible	70% subject to the deductible	Coverage only for diagnosis, counseling and planning.
Maternity/ Birthing Centers	100% subject to the deductible	70% subject to the deductible	Hospital associated facilities only.

Mental Health/Substance Abuse Benefit

Services not specifically listed below will pay the same as any other illness. For example, office visits, therapy visits, urgent care, and emergency room visits will be charged the same as a similar visit for any other illness.

Service	In Network Benefit	Out of Network Benefit	Limitations
Inpatient Facility	100% subject to the deductible	70% subject to the deductible	Based on the semi-private room rate.
Inpatient Miscellaneous Charges	100% subject to the deductible	70% subject to the deductible	Excludes patient convenience items.

Prescription Drugs

Prescription copays apply toward the medical benefits out-of-pocket maximums.

Service	In Network Benefit	Out of Network Benefit	Limitations
Generic Drugs	$10 copay per up to 90 day prescription or refill, then paid at . 100%	Covered same as In Network Benefit	Up to a 90-day supply. Not subject to the deductible.
Preferred Drugs	$40 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 34-day supply. Not subject to the deductible.
Non-Preferred Drugs	$80 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 34-day supply. Not subject to the deductible.
Specialty/ Biotech Drugs	80% coinsurance. Up to a maximum member payment of $80, not subject to deductible	Covered same as In Network Benefit	Limited to a 34-day supply. May be required to use an approved specialty pharmacy.
Mail-in Generic Drugs	$20 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 90-day supply. Not subject to the deductible.
Mail-in Preferred Drugs	$80 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 90-day supply. Not subject to the deductible.
Mail-in Non-Preferred Drugs	$160 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 90-day supply. Not subject to the deductible.

Specific Surgery and Treatment

Services	In Network Benefit	Out of Network Benefit	Limitations
Bariatric Surgery	50% subject to the deductible	Not covered	Limited to 1 per lifetime. Prior approval required.
Reconstructive Surgery	50% subject to the deductible	Not covered	Prior approval required. Includes blepharoplasty of upper lids, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and male gynecomastia.
Skin Disorders	50% subject to the deductible	Not covered	Prior approval required. Limited to treatment for scar revisions, keloid scar, hyperhidrosis, vitiligo, port wine stain and hemangioma. Also, excisions of lipomas, seborrheic keratoses and skin tags.
Varicose Veins	50% subject to the deductible	Not covered	Prior approval required.
Organ Transplant Facility	100% subject to the deductible	70% subject to the deductible	Prior approval is required.
Organ Transplant Physician	100% subject to the deductible	70% subject to the deductible	
Temporomandibular Joint Syndrome (TMJ) Facility	100% subject to the deductible	70% subject to the deductible	Subject to a calendar year maximum of $500.
Temporomandibular Joint Syndrome (TMJ) Physician	100% subject to the deductible	70% subject to the deductible	

Therapy Services - Outpatient

Services	In Network Benefit	Out of Network Benefit	Limitations
Physical Therapy, Occupational Therapy, and Chiropractic Services	$35 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Limited to a combined 30 visits per calendar year.
Speech Therapy	$35 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Limited to 30 visits per calendar year.
Cardiac and Pulmonary Rehabilitation	$35 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Limited to a combined 30 visits per calendar year.

The following are considered "Preventive Benefits" under the Patient Protection & Affordable Care Act and are covered by the Plan and payable at 100% not subject to the deductible or copays when services are rendered at an In Network Benefit provider.

- Immunizations for children and adults as required by federal regulation.
- Screening for abdominal aortic aneurysm – one time screening for abdominal aortic aneurysm by ultrasonography for men age 65-75 who have ever smoked.
- Screening and counseling to reduce alcohol misuse.
- Aspirin to prevent CVD for men age 45-79 and women age 55-79.
- Screening for autism for children age 2 and under.
- Screening for bacteriuria- screening with urine culture for pregnant women.
- Behavioral assessments for children under age 18.
- Screening for high blood pressure – adults age 18 and older.
- Counseling related to BRCA screening for women at higher risk.
- Screening for breast cancer (mammography) every 1 to 2 years for women age 40 and over.
- Chemoprevention of breast cancer for women at higher risk.
- Interventions to support breast feeding – Interventions during pregnancy and after birth to promote breastfeeding.
- Screening for cervical cancer for sexually active females.
- Screening for Chlamydia infection for women who are pregnant, age 24 or younger and older women at higher risk.
- Screening for cholesterol abnormalities for men and women at higher risk.
- Screening for colorectal cancer – screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy or colonoscopy in adults age 50 and older.
- Chemoprevention of dental caries –oral fluoride supplementation for children whose primary water source is deficient in fluoride.
- Screening for depression starting at age 12.
- Developmental screenings for children under age 3.
- Screening for diabetes – screening for type 2 diabetes for adults with high blood pressure.
- Screening for dyslipidemia for children at higher risk of lipid disorders.
- Counseling for healthy diet – intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by a primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
- Supplementation with folic acid for all women who may become pregnant.
- Screening for gonorrhea for women at higher risk.
- Prophylactic medication for gonorrhea for all newborns. Screening for hearing loss for all newborns.
- Height, weight and body mass index measurements of children under age 18.
- Hematocrit or Hemoglobin screening for children under age 18.
- Screening for hemoglobinopathies – screening for sickle cell disease in newborns.
- Screening for hepatitis B – screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
- Screening for HIV – screening for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection and all pregnant women.
- Screening for HPV for all women.
- Screening congenital hypothyroidism – screening for congenital hypothyroidism in newborns.
- Screening for iron deficiency anemia – screening for iron deficiency anemia in asymptomatic pregnant women.
- Iron supplementations in children – routine iron supplementation for asymptomatic children age 6 to 12 months at risk for anemia.
- Screening for lead for children at risk of exposure.
- Medical history for all children throughout development.
- Screening and counseling for obesity for adults and children. Intensive counseling can be delivered by a primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
- Oral health risk assessment for children under age 12.
- Screening for osteoporosis for women age 60 and older at higher risk.
- Screening for PKU – screening for phenylketonuria (PKU) in newborns.
- Screening for Rh for all pregnant women and follow up testing for women at higher-risk.
- Counseling for STIs – behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and adults at increased risk and pregnant women.
- Screening for syphilis for all pregnant women and adults at higher risk.
- Counseling for tobacco use – for age 18 and older tobacco users, this benefit provides tobacco cessation interventions and tobacco products.
- Counseling for tobacco use for pregnant women.
- Tuberculin testing for children at higher risk of tuberculosis.
- Screening for visual acuity in children – screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than 5 years.
- Screening for gestational diabetes for pregnant women.
- Screening and counseling for interpersonal and domestic violence for women.
- FDA-approved contraception methods and contraceptive counseling for women. Does not include over the counter contraception.
- Routine prenatal office visits.

Chronic Disease Management (CDM) Benefits

The Plan offers a Chronic Disease Management (CDM) Benefit. The conditions listed below shall have the listed visits and services given by an In Network provider payable at 100% and not subject to the deductible or copay. Once the service maximum benefit has been met, eligible charges shall be payable according to the standard plan benefits. The provider must provide the appropriate billing including diagnosis codes and CPT codes for the Chronic Disease Management Benefit to apply. If a covered person has more than one CDM diagnosis, the primary diagnosis billed will determine the benefit payable.

*The services listed below are the standard laboratory and diagnostic procedure for each chronic disease.

Condition	Covered Office Visits	Covered Laboratory Services
Asthma	2 office visit copays waived per calendar year	Spirometry
Atrial Fibrillation	1 office visit copay waived per calendar year	EKG; Prothrombin times
Chronic Obstructive Pulmonary Disease	2 office visit copays waived per calendar year	Spirometry
Chronic Renal Insufficiency	2 office visit copays waived per calendar year	Creatinine; Complete Blood Count (CBC); Electrolytes; Urine Protein; Serum Calcium; Serum Phosphorus; Lipid Panel
Congestive Heart Failure	2 office visit copays waived per calendar year	BUN; Creatinine; Potassium
Coronary Artery Disease	1 office visit copay waived per calendar year	Lipid Panel; EKG; Cholesterol
Depression	4 office visit copays waived per calendar year	No associated labs
Diabetes	2 office visit copays waived per calendar year	Glycohemoglobins; Microalbumin; Lipid Panel
Epilepsy	1 office visit copay waived per calendar year	No associated labs
Hyperlipidemia	1 office visit copay waived per calendar year	Lipid Panel; Cholesterol
Hypertension	2 office visit copays waived per calendar year	No associated labs
Hyperthyroidism*	1 office visit copay waived per calendar year	Thyroid Stimulating Hormone (TSH) Thyroxine (T4)
Hypothyroidism	1 office visit copay waived per calendar year	Thyroid Stimulating Hormone (TSH) Thyroxine (T4)
Metabolic Syndrome	1 office visit copay waived per calendar year	Lipid Panel Glucose FBS or Hemoglobin A1c (HgbA1c)
Multiple Sclerosis	2 office visit copays waived per calendar year	No associated labs
Parkinson's Disease	2 office visit copays waived per calendar year	No associated labs
Peripheral Vascular Disease (Atherosclerosis)	1 office visit copay waived per calendar year	Lipid Panel
Pre-Diabetes	1 office visit copay waived per calendar year	Lipid Panel Glucose FBS or Hemoglobin A1c (HgbA1c)
Polymyalgia Rheumatica	2 office visit copays waived per calendar year	Erythrocyte Sedimentation Rate (ESR) or C-Reactive Protein (CRP) Complete Blood Count (CBC)
Pulmonary Hypertension (unrelated to COPD)	2 office visit copays waived per calendar year	No associated labs
COPD with Pulmonary Hypertension COR Pulmonale	2 office visit copays waived per calendar year	Spirometry 12 Months of Supplemental Oxygen Treatment
Rheumatoid Arthritis	1 office visit copay waived per calendar year	Complete Blood Count (CBC)
Sleep Apnea	1 office visit copay waived per calendar year	No associated labs
Chronic Venous Thrombotic Disease	2 office visit copays waived per calendar year	No associated labs
Ulcerative Colitis (Inflammatory Bowel Disease)	1 office visit copay waived per calendar year	Complete Blood Count (CBC) LFT

Schedule of Copayments and Deductibles

Deductibles

Type	In Network Benefit	Out of Network Benefit
Individual	$500 per calendar year	$1,000 per covered person per calendar year
Family	$1,000 per family per calendar year	$2,000 per family per calendar year

- Out of Network deductibles are separate from In Network deductibles.
- Deductibles apply toward out-of-pocket maximums.

Individual Coinsurance

In Network Benefit	Out of Network Benefit
100%	70%

- The plan pays the above percentages of eligible charges, unless otherwise stated, after the deductible is satisfied.
- The plan pays 100% for the remainder of the calendar year *after* the out-of-pocket maximum has been reached.

Out-of-pocket Maximums

Type	In Network Benefit	Out of Network Benefit
Individual Maximum	$2,000 per covered person per calendar year	$5,000 per covered person per calendar year
Family Maximum	$4,000 per family per calendar year	$10,000 per family per calendar year

- Out of Network out-of-pocket maximums are separate from In Network out-of-pocket maximums.
- Deductibles, copayments and coinsurances apply toward out-of-pocket maximums.

Physician Office Services and Urgent and Emergency Care Services

Service	In Network Benefit	Out of Network Benefit	Limitations
Primary Care Physician's Office Visit.	$20 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Coverage includes labs, x-rays, injections, and medical supplies rendered in the office on the same day. Does not include MRI's, CT and PET scans.
Specialist Physician's Office Visit	$35 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	
Urgent Care Visit	$50 copay, then paid 100% not subject to the deductible	$50 copay, then paid 100% not subject to the deductible	Must be medically necessary.
Emergency Room	$150 copay, then paid at 100% not subject to the deductible	$150 copay, then paid at 100% not subject to the deductible	ER per visit copay waived if admitted. Out-of-Network benefit services are subject to the In-Network benefit out of pocket.
Land/Air Ambulance	100% subject to the deductible	70% subject to the deductible	Not applicable.
Office Surgery	100% subject to the deductible	70% subject to the deductible	Not applicable.

Hospital and Surgical Services (including newborn hospital care)

Service	In Network Benefit	Out of Network Benefit	Limitations
Room and Board	100% subject to the deductible	70% subject to the deductible	Based on the semi-private room rate. Charges for routine newborn care are covered under the mother for up to 5 days.
Miscellaneous Charges	100% subject to the deductible	70% subject to the deductible	Excludes patient convenience items.
Inpatient Surgery	100% subject to the deductible	70% subject to the deductible	Not applicable.
Assistant Surgeons	Charges are limited to a maximum benefit of 25% of the surgeon's allowable amount.		
Office/ Outpatient Surgery	100% subject to the deductible	70% subject to the deductible	Not applicable.
Inpatient Physician Hospital Visits	100% subject to the deductible	70% subject to the deductible	Not applicable.

Diagnostic and Preventive Services

Service	In Network Benefit	Out of Network Benefit	Limitations
Preventive & Wellness	100% not subject to the deductible	70% subject to the deductible	Routine services not part of the Patient Protection & Affordable Care Act listed below will be payable as any other illness.
Office Visit Medical Supplies	100%	70% subject to the deductible	Office copay applies if no office exam billed.
Lab and X-ray: in office	100%	70% subject to the deductible	Office copay applies if no office exam billed.
Lab: non-office facility	$20 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Includes services rendered outpatient hospital.
X-ray: non-office facility	$20 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Includes services rendered outpatient hospital.
X-ray: MRI/CT scan/PET scan	$150 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Prior approval is required.
In-office Medical & Allergy Injections	100%	70% subject to the deductible	Office copay applies if office exam billed.

Other Covered Services

Service	In Network Benefit	Out of Network Benefit	Limitations
Durable Medical Equipment	100% subject to the deductible	70% subject to the deductible	Not applicable.
Home Health Care	100% subject to the deductible	70% subject to the deductible	Not applicable.
Hospice Care	100% subject to the deductible	70% subject to the deductible	Prior approval required for charges received after 6 months.

Service	In Network Benefit	Out of Network Benefit	Limitations
Prosthetics	100% subject to the deductible	70% subject to the deductible	Not applicable.
Skilled Nursing Services	100% subject to the deductible	70% subject to the deductible	Limited to 45 days per calendar year.
Infertility Services	100% subject to the deductible	70% subject to the deductible	Coverage only for diagnosis, counseling and planning.
Maternity/ Birthing Centers	100% subject to the deductible	70% subject to the deductible	Hospital associated facilities only.

Mental Health/Substance Abuse Benefit

Services not specifically listed below will pay the same as any other illness. For example, office visits, therapy visits, urgent care, and emergency room visits will be charged the same as a similar visit for any other illness.

Service	In Network Benefit	Out of Network Benefit	Limitations
Inpatient Facility	100% subject to the deductible	70% subject to the deductible	Based on the semi-private room rate.
Inpatient Miscellaneous Charges	100% subject to the deductible	70% subject to the deductible	Excludes patient convenience items.

Prescription Drugs

Prescription copays apply toward the medical benefits out-of-pocket maximums.

Service	In Network Benefit	Out of Network Benefit	Limitations
Generic Drugs	$10 copay per up to 90 day prescription or refill, then paid at 100%	Covered same as In Network Benefit	Up to a 90-day supply. Not subject to the deductible.
Preferred Drugs	$40 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 34-day supply. Not subject to the deductible.
Non-Preferred Drugs	$80 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 34-day supply. Not subject to the deductible.
Specialty/ Biotech Drugs	80% coinsurance. Up to a maximum member payment of $80, not subject to deductible	Covered same as In Network Benefit	Limited to a 34-day supply. May be required to use an approved specialty pharmacy.
Mail-in Generic Drugs	$20 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 90-day supply. Not subject to the deductible.
Mail-in Preferred Drugs	$80 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 90-day supply. Not subject to the deductible.
Mail-in Non-Preferred Drugs	$160 copay per prescription or refill, then paid at 100%	Covered same as In Network Benefit	Limited to a 90-day supply. Not subject to the deductible.

Specific Surgery and Treatment

Services	In Network Benefit	Out of Network Benefit	Limitations
Bariatric Surgery	50% subject to the deductible	Not covered	Limited to 1 per lifetime. Prior approval required.
Reconstructive Surgery	50% subject to the deductible	Not covered	Prior approval required. Includes blepharoplasty of upper lids, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and male gynecomastia.
Skin Disorders	50% subject to the deductible	Not covered	Prior approval required. Limited to treatment for scar revisions, keloid scar, hyperhidrosis, vitiligo, port wine stain and hemangioma. Also, excisions of lipomas, seborrheic keratoses and skin tags.
Varicose Veins	50% subject to the deductible	Not covered	Prior approval required.
Organ Transplant Facility	100% subject to the deductible	70% subject to the deductible	Prior approval is required.
Organ Transplant Physician	100% subject to the deductible	70% subject to the deductible	
Temporomandibular Joint Syndrome (TMJ) Facility	100% subject to the deductible	70% subject to the deductible	Subject to a calendar year maximum of $500.
Temporomandibular Joint Syndrome (TMJ) Physician	100% subject to the deductible	70% subject to the deductible	

Therapy Services - Outpatient

Services	In Network Benefit	Out of Network Benefit	Limitations
Physical Therapy, Occupational Therapy, and Chiropractic Services	$35 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Limited to a combined 30 visits per calendar year.
Speech Therapy	$35 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Limited to 30 visits per calendar year.
Cardiac and Pulmonary Rehabilitation	$35 copay, then paid at 100% not subject to the deductible	70% subject to the deductible	Limited to a combined 30 visits per calendar year.

The following are considered "Preventive Benefits" under the Patient Protection & Affordable Care Act and are covered by the Plan and payable at 100% not subject to the deductible or copays when services are rendered at an In Network Benefit provider.

- Immunizations for children and adults as required by federal regulation.
- Screening for abdominal aortic aneurysm – one time screening for abdominal aortic aneurysm by ultrasonography for men age 65-75 who have ever smoked.
- Screening and counseling to reduce alcohol misuse.
- Aspirin to prevent CVD for men age 45-79 and women age 55-79.
- Screening for autism for children age 2 and under.
- Screening for bacteriuria- screening with urine culture for pregnant women.
- Behavioral assessments for children under age 18.
- Screening for high blood pressure – adults age 18 and older.
- Counseling related to BRCA screening for women at higher risk.
- Screening for breast cancer (mammography) every 1 to 2 years for women age 40 and over.
- Chemoprevention of breast cancer for women at higher risk.
- Interventions to support breast feeding – Interventions during pregnancy and after birth to promote breastfeeding.
- Screening for cervical cancer for sexually active females.
- Screening for Chlamydia infection for women who are pregnant, age 24 or younger and older women at higher risk.
- Screening for cholesterol abnormalities for men and women at higher risk.
- Screening for colorectal cancer – screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy or colonoscopy in adults age 50 and older.
- Chemoprevention of dental caries –oral fluoride supplementation for children whose primary water source is deficient in fluoride.
- Screening for depression starting at age 12.
- Developmental screenings for children under age 3.
- Screening for diabetes – screening for type 2 diabetes for adults with high blood pressure.
- Screening for dyslipidemia for children at higher risk of lipid disorders.
- Counseling for healthy diet – intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by a primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
- Supplementation with folic acid for all women who may become pregnant.
- Screening for gonorrhea for women at higher risk.
- Prophylactic medication for gonorrhea for all newborns.
- Screening for hearing loss for all newborns.
- Height, weight and body mass index measurements of children under age 18.
- Hematocrit or Hemoglobin screening for children under age 18.
- Screening for hemoglobinopathies – screening for sickle cell disease in newborns.
- Screening for hepatitis B – screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
- Screening for HIV – screening for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection and all pregnant women.
- Screening for HPV for all women.
- Screening congenital hypothyroidism – screening for congenital hypothyroidism in newborns.
- Screening for iron deficiency anemia – screening for iron deficiency anemia in asymptomatic pregnant women.
- Iron supplementations in children – routine iron supplementation for asymptomatic children age 6 to 12 months at risk for anemia.
- Screening for lead for children at risk of exposure.
- Medical history for all children throughout development.
- Screening and counseling for obesity for adults and children. Intensive counseling can be delivered by a primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
- Oral health risk assessment for children under age 12.
- Screening for osteoporosis for women age 60 and older at higher risk.
- Screening for PKU – screening for phenylketonuria (PKU) in newborns.
- Screening for Rh for all pregnant women and follow up testing for women at higher-risk.
- Counseling for STIs – behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and adults at increased risk and pregnant women.
- Screening for syphilis for all pregnant women and adults at higher risk.
- Counseling for tobacco use – for age 18 and older tobacco users, this benefit provides tobacco cessation interventions and tobacco products.
- Counseling for tobacco use for pregnant women.
- Tuberculin testing for children at higher risk of tuberculosis.
- Screening for visual acuity in children – screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than 5 years.
- Screening for gestational diabetes for pregnant women.
- Screening and counseling for interpersonal and domestic violence for women.
- FDA-approved contraception methods and contraceptive counseling for women. Does not include over the counter contraception.
- Routine prenatal office visits.

Chronic Disease Management (CDM) Benefits

The Plan offers a Chronic Disease Management (CDM) Benefit. The conditions listed below shall have the listed visits and services given by an In Network provider payable at 100% and not subject to the deductible or copay. Once the service maximum benefit has been met, eligible charges shall be payable according to the standard plan benefits. The provider must provide the appropriate billing including diagnosis codes and CPT codes for the Chronic Disease Management Benefit to apply. If a covered person has more than one CDM diagnosis, the primary diagnosis billed will determine the benefit payable.

*The services listed below are the standard laboratory and diagnostic procedure for each chronic disease.

Condition	Covered Office Visits	Covered Laboratory Services
Asthma	2 office visit copays waived per calendar year	Spirometry
Atrial Fibrillation	1 office visit copay waived per calendar year	EKG; Prothrombin times
Chronic Obstructive Pulmonary Disease	2 office visit copays waived per calendar year	Spirometry
Chronic Renal Insufficiency	2 office visit copays waived per calendar year	Creatinine; Complete Blood Count (CBC); Electrolytes; Urine Protein; Serum Calcium; Serum Phosphorus; Lipid Panel
Congestive Heart Failure	2 office visit copays waived per calendar year	BUN; Creatinine; Potassium
Coronary Artery Disease	1 office visit copay waived per calendar year	Lipid Panel; EKG; Cholesterol
Depression	4 office visit copays waived per calendar year	No associated labs
Diabetes	2 office visit copays waived per calendar year	Glycohemoglobins; Microalbumin; Lipid Panel
Epilepsy	1 office visit copay waived per calendar year	No associated labs
Hyperlipidemia	1 office visit copay waived per calendar year	Lipid Panel; Cholesterol
Hypertension	2 office visit copays waived per calendar year	No associated labs
Hyperthyroidism	1 office visit copay waived per calendar year	Thyroid Stimulating Hormone (TSH) Thyroxine (T4)
Hypothyroidism	1 office visit copay waived per calendar year	Thyroid Stimulating Hormone (TSH) Thyroxine (T4)
Metabolic Syndrome	1 office visit copay waived per calendar year	Lipid Panel Glucose FBS or Hemoglobin A1c (HgbA1c)
Multiple Sclerosis	2 office visit copays waived per calendar year	No associated labs
Parkinson's Disease	2 office visit copays waived per calendar year	No associated labs
Peripheral Vascular Disease (Atherosclerosis)	1 office visit copay waived per calendar year	Lipid Panel
Pre-Diabetes	1 office visit copay waived per calendar year	Lipid Panel Glucose FBS or Hemoglobin A1c (HgbA1c)
Polymyalgia Rheumatica	2 office visit copays waived per calendar year	Erythrocyte Sedimentation Rate (ESR) or C-Reactive Protein (CRP) Complete Blood Count (CBC)
Pulmonary Hypertension (unrelated to COPD)	2 office visit copays waived per calendar year	No associated labs
COPD with Pulmonary Hypertension COR Pulmonale	2 office visit copays waived per calendar year	Spirometry 12 Months of Supplemental Oxygen Treatment
Rheumatoid Arthritis	1 office visit copay waived per calendar year	Complete Blood Count (CBC)
Sleep Apnea	1 office visit copay waived per calendar year	No associated labs
Chronic Venous Thrombotic Disease	2 office visit copays waived per calendar year	No associated labs
Ulcerative Colitis (Inflammatory Bowel Disease)	1 office visit copay waived per calendar year	Complete Blood Count (CBC) LFT