Classified Employees & Classified Supervisors

Medical & Pharmacy Summary

	Select Basic	Select	Choice		HDHP
Benefit			**Network**	**Non-Network**	
Choice of Physician	Member selects a physician from the network	Member selects a physician from the network	Member selects a physician from the network	Member selects a non-network physician at a lower benefit	Member selects a physician from the network
	Annual Medical Deductible - Deductible applies except for services with a copay unless otherwise noted				
Medical Deductible Individual/Family	$300/$900	$300/$900	$150/$300	$900/$2,700	In-Network: $1,650/$3,300 Out-of-Network: $3,300/$6,600
Annual Out-Of-Pocket Maximum (OOP)	**Network medical copayments will accumulate to the Out-Of-Pocket Maximum along with any applicable medical deductibles and coinsurance. (See Pharmacy Out-Of-Pocket Maximum below)**				
Medical OOP Individual/Family	$750/$1,500	$750/$1,500	$750/$1,500	$2,250/$4,500	In-Network: $1,650/$3,300 Out-of-Network: $3,300/$6,600
Preventive Care Services (Routine preventive care services)	$0 Copay	$0 Copay	$0 Copay	Not Covered	$0 before deductible
Physician Office Visits	$20 Copay	$15 Copay	$15 Copay	30% Coinsurance after deductible	100% until deductible met then $0
Specialist Office Visits	$30 Copay	$30 Copay	$30 Copay	30% Coinsurance after deductible	100% until deductible met then $0
Urgent Care Visits	$50 Copay	$50 Copay	$50 Copay	Not Covered	100% until deductible met then $0
Hospital Emergency Room	$200 Copay (waived if admitted)	$200 Copay (waived if admitted)	$200 Copay (waived if admitted)	$200 Copay (waived if admitted)	100% until deductible met then $0
Inpatient Facility Services	10% Coinsurance after deductible	10% Coinsurance after deductible No PM&R limit	5% Coinsurance after deductible 60 day combined PM&R limit	30% Coinsurance after deductible 60 day PM&R limit	100% until deductible met then $0
Outpatient Facility Services	10% Coinsurance after deductible	10% Coinsurance after deductible	5% Coinsurance after deductible	30% Coinsurance after deductible	100% until deductible met then $0
Chiropractic Services (30 visits/year)	$20 Copay	$20 Copay	$20 Copay	30% Coinsurance after deductible	100% until deductible met then $0
Physical & Occupational Therapy (60 visits/year combined)	$20 Copay	$20 Copay	$20 Copay	30% Coinsurance after deductible	100% until deductible met then $0
Speech Therapy (20 visits/year)	$20 Copay	$20 Copay	$20 Copay	30% Coinsurance after deductible	100% until deductible met then $0
DME - Medical Supplies, Equipment, & Appliances	20% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	100% until deductible met then $0
Diabetic/Asthmatic Supplies	$0 Copay	$0 Copay	$0 Copay	Not Covered	100% until deductible met then $0
Human Organ/Tissue Transplant	Plan pays 100%	Plan pays 100%	Plan pays 100%	Not Covered	100% until deductible met then $0
Hearing Aids	$0 Copay	$0 Copay	$0 Copay	30% Coinsurance after deductible	100% until deductible met then $0
Mental Health/Substance Abuse Inpatient Services	10% Coinsurance after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible	20% Coinsurance after deductible	100% until deductible met then $0
Mental Health/Substance Abuse Outpatient Services	$20 Copay	$15 Copay	$15 Copay	20% Coinsurance	100% until deductible met then $0
Home Health Care	0% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible (30 visit limit/year)	100% until deductible met then $0
Hospice Services	0% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible	100% until deductible met then $0
Pharmacy OOP Individual/Family	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$2,500/$5,000	100% until deductible met then $0 *Select generic preventive drugs offered at no cost.
Prescription Drugs Retail Pharmacy (30 day supply)	$14 Generic/ $25 Brand Preferred/ $40 Brand Non-Preferred	$7 Generic/ $18 Brand Preferred/ $35 Brand Non-Preferred	$7 Generic/ $18 Brand Preferred/ $35 Brand Non-Preferred	50% Coinsurance	100% until deductible met then $0
Prescription Drugs Retail Pharmacy (90 day supply)	$28 Generic/ $50 Brand Preferred/ $80 Brand Non-Preferred	$14 Generic/ $35 Brand Preferred/ $70 Brand Non-Preferred	$14 Generic/ $35 Brand Preferred/ $70 Brand Non-Preferred	Not Covered	100% until deductible met then $0
Dependent Child Age	Up to age 26				

Note: Above summaries are for reference only. Please consult Summary Plan Document, amendments, and riders for exact plan benefits.