

2016 Active Employee Medical Plans - Grant County, Effective January 1, 2016



	Core Plan		Buy Up Plan	
<i>Medical Benefits</i>	<i>In Network</i>	<i>Out of Network</i>	<i>In Network</i>	<i>Out of Network</i>
Lifetime Maximum	Unlimited		Unlimited	
Annual Deductible	\$750/\$2,250		\$500/\$1,500	
Out-of-Pocket Maximum (Includes deductible and copays including prescription drugs)	\$3,250/\$7,250	Unlimited	\$3,000/\$6,500	Unlimited
Co-Insurance	80/20	60/40	80/20	60/40
Office Visit	\$30 Copay	60/40 after deductible	\$25 Copay	60/40 after deductible
Diagnostic X-Ray & Lab	80/20 after deductible	60/40 after deductible	Covered in full	60/40 after deductible
Hospital				
• Inpatient	80/20 after deductible	60/40 after deductible	80/20 after deductible	60/40 after deductible
• Outpatient	\$100 copay then 80/20 after deductible	\$100 copay then 60/40 after deductible	\$100 copay then 80/20 after deductible	\$100 copay then 60/40 after deductible
• Emergency	\$200 Copay (Copay waived if admitted); 80/20 after deductible		\$200 Copay (Copay waived if admitted); 80/20 after deductible	
Prescription Drugs				
• Retail	\$20/\$40/\$75 Copay	\$20/\$40/\$75 Copay; then 60/40	\$15/\$25/\$50 Copay	\$15/\$25/\$50 Copay; then 60/40
• Mail Order	\$40/\$80/\$150 Copay	\$40/\$80/\$150 Copay; then 60/40	\$30/\$50/\$100 Copay	\$30/\$50/\$100 Copay; then 60/40
• Specialty	\$125 copay	Not Available	\$125 copay	Not Available
Preventive Care (includes Preventive DX&L)	Covered in full	60/40 after deductible	Covered in full	60/40 after deductible
Preventive Immunizations	Covered in full	60/40 (deductible waived)	Covered in full	60/40 (deductible waived)
Mammography	Covered in full	70/30 after deductible	Covered in full	70/30 after deductible
Chiropractic (Unlimited)	\$30 Copay	60/40 after deductible	\$25 Copay	60/40 after deductible
Mental Health				
• Inpatient	80/20 after deductible	60/40 after deductible	80/20 after deductible	60/40 after deductible
• Outpatient	\$30 Copay	60/40 after deductible	\$25 Copay	60/40 after deductible
Vision Exam (1 PCY)	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay
Vision Hardware	Covered in full up to \$300 maximum per member PCY	Covered in full up to \$300 maximum per member PCY	Covered in full up to \$300 maximum per member PCY	Covered in full up to \$300 maximum per member PCY

This is not a contract. This is a summary of benefits.

