

City of Maumee - 2010 Employee Health Care Plan

Medical Benefits

Lifetime Maximum (per person): \$5,000,000

	Front Path Network Provider	Non-Network Provider
	The following Front Path Network services are subject to a co-pay only. Deductible and co-insurance do not apply.	The following services are subject to a deductible before a plan payment is made. After the deductible is met, the Employee is responsible for the insurance portion.
Physician Office Visits (Includes the following: Family Practitioner, General Practitioner, Internal Medicine, Pediatric Practitioner, Osteopathic Medicine, and Obstetrics - Gynecology Medicine)	\$ 15 co-pay	70% co-insurance after deductible is met.
Teladoc / Telemedicine	\$ 15 co-pay	\$ 15 co-pay
Specialist Office Visits	\$ 25 co-pay	70% co-insurance after deductible is met.
Urgent Care	\$ 50 co-pay	70% co-insurance after deductible is met.
Emergency Room	\$ 75 co-pay	70% co-insurance after deductible is met.
Non-Emergency	\$ 100 co-pay	70% co-insurance after deductible is met.
Outpatient Diagnostic X-Rays and Laboratory Testing (not including CT Scan, PET Scan, or MRI)	100%	70% co-insurance after deductible is met.
Smoking Cessation (Claims manually submitted.)	100% \$250 Lifetime maximum.	100% \$250 Lifetime maximum.
Preventive Care		
Routine Well Adult Care	100% after \$15 copay. \$500 calendar year maximum. Includes - Office visit, pap smear, prostate screening, gynecological exam, routine physical examination, and sigmoidoscopy.	70% co-insurance after deductible is met. \$500 calendar year maximum. Includes - Office visit, pap smear, prostate screening, gynecological exam, routine physical examination, and sigmoidoscopy.
Mammogram (Screening)	100% Limited to 1 per year and to age 35 and over.	70% co-insurance after deductible is met. Limited to 1 per year and to age 35 and over.
Colonoscopy	100% Limited to 1 per year and to age 50 and over.	70% co-insurance after deductible. Limited to 1 per year and to age 50 and over.
Routine Well Newborn Care	100% after \$15 copay. \$750 calendar year maximum from birth to age 24 months Includes - Office visits, routine physical examination, hearing tests, vision and immunizations through age 18.	70% co-insurance after deductible. \$750 calendar year maximum from birth to age 24 months \$500 calendar year maximum until age 18 Includes - Office visits, routine physical examination, hearing tests, vision and immunizations through age 18.
Routine Well Child Care	100% after \$15 copay. \$500 calendar year maximum until age 18 Includes - Office visits, routine physical examination, hearing tests, vision and immunizations through age 18.	70% co-insurance after deductible. \$750 calendar year maximum from birth to age 24 months \$500 calendar year maximum until age 18 Includes - Office visits, routine physical examination, hearing tests, vision and immunizations through age 18.
Medical Benefits		
	Front Path Network Provider The following Front Path Network services are subject to a deductible before a plan payment is made. After the deductible is met, the Employee is responsible for the co-insurance portion.	Non-Network Provider The following Non-Network services are subject to a "deductible" before a plan payment is made. After the deductible is met, the Employee is responsible for the co-insurance portion. The Non-Network deductible is separate from the "Front Path Network" deductible.
Per Person Per Family	Deductible (Employee pays first). \$ 200 \$ 400	Deductible (Employee pays first). \$ 400 \$ 800
Per Person Per Family	Co-insurance (10% of the charges for service) \$ 500 \$ 1,500	Co-insurance (30% of the charges for service) \$ 1,000 \$ 3,000
Per Person Per Family	Max Out-of-Pocket (Deductible + Coinsurance) \$ 700 \$ 1,900	Max Out-of-Pocket (Deductible + Coinsurance) \$ 1,400 \$ 3,800
Amulance	90% co-insurance after deductible is met.	90% co-insurance after deductible is met.
Inpatient Hospital	90% co-insurance after deductible is met.	70% co-insurance after deductible is met.
Surgery	90% co-insurance after deductible is met.	70% co-insurance after deductible is met.
Skilled Nursing Facility	90% co-insurance after deductible is met of the facility's semiprivate room rate within 3 days of a 3 day hospital stay, calendar maximum	70% co-insurance after deductible is met of the facility's semiprivate room rate within 3 days of a 3 day hospital stay, calendar maximum
CT Scan, PET Scan, MRI (and inpatient x-rays and laboratory testing)	90% co-insurance after deductible is met.	70% co-insurance after deductible is met.
Physical Therapy	90% co-insurance after deductible is met. 8 sessions per year	70% co-insurance after deductible is met. 8 sessions per year
Occupational Therapy	90% co-insurance after deductible is met. 8 sessions per year	70% co-insurance after deductible is met. 8 sessions per year
Speech Therapy	90% co-insurance after deductible is met. 8 sessions per year	70% co-insurance after deductible is met. 8 sessions per year
Chiropractic	90% co-insurance after deductible is met. Maximum 25 visits per year.	70% co-insurance after deductible is met. Maximum 25 visits per year.
Durable Medical Equipment	90% co-insurance after deductible is met. \$1,000 calendar year maximum.	70% co-insurance after deductible is met. \$1,000 calendar year maximum.
Organ Transplants	90% co-insurance after deductible is met. Lifetime maximum for donor.	70% co-insurance after deductible is met. Lifetime maximum for donor.
Pregnancy	90% co-insurance after deductible is met.	70% co-insurance after deductible is met.
Dental Benefits		
	No provider network, patient may use any area dentist. The plan will pay "usual, customary, and reasonable (UCR)" costs to provider with the patient responsible for any amount over UCR. Maximum dental benefit \$1,500 per person per year (unchanged).	Class B (Basic - Class C Orthodontia is covered 60% (no deductible) and has been increased to \$1,500 lifetime maximum per eligible dependent to age 19.
Prescription Drug Benefits		
	Retail	Mail Order
Generic	30-day supply \$ 10	90-day supply \$ 20
Preferred ("Formulary") Brand	\$ 25	\$ 50
Non-Preferred Brand	\$ 40	\$ 80
	Prescriptions purchased via retail are only covered at participating pharmacies.	
Vision Benefits (VSP)		
Benefit	Co-Pay	Description
Well Vision Exam	\$25 for exam and/or eyewear	Eye exam every 12 months beginning in January.
Prescription Lenses	\$25 for exam and/or eyewear	New lenses every 12 months. Covers single vision, lined bifocal, and lined trifocal lenses.
Frame	\$25 for exam and/or eyewear	New frame (with a \$130 allowance + 20% discount over allowance) every 24 months
Contacts Instead of Glasses	None	New contacts every 12 months with a 15% discount off the contact lens exam and a \$130 allowance for contact lens exam and contacts.