



**SCHEDULE OF BENEFITS**  
**HDHP**  
 (All active employees EXCEPT Transit Union)

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in your Summary Plan Description. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read the entire summary plan description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

<b>Your Responsibilities</b>	<b>In network</b>	<b>Out of network</b>
<b>Deductible*</b>	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family
<b>Coinsurance*</b>	10%	30%
<b>Annual Coinsurance Limit</b>	\$1,000 individual \$2,000 family	\$2,500 individual \$5,000 family
<b>Annual Deductible and Coinsurance Limit</b>	\$2,500 individual \$5,000 family	\$5,000 individual \$10,000 family
<b>Out of Pocket Maximum</b> (Deductible, coinsurance, and medical copayments)  In-network amounts accumulate to the out-of-network out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	\$6,400 individual \$12,900 family  The individual in-network out of pocket is limited to \$6,400 when enrolled in a family plan.	\$8,900 individual \$17,900 family
* The family deductible and coinsurance can be satisfied by <b>one</b> family member. The deductible must be satisfied before the plan will make any payment for services (other than preventive services).		

<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Ambulance services</b>	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
<b>Anesthesia services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Autism services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Chiropractic Services</b> (Includes chiropractic office visit. No coverage for maintenance therapy.)	Subject to deductible and coinsurance	Subject to deductible and coinsurance



<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Durable medical equipment and medical supplies</b> (Including insulin pump and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hearing aids and implantable hearing devices</b> (Limited to children up to age 18)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hearing examinations</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Home health care</b> (Limited to 100 visits per 12 month period)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospice care</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Home hospice</b> (Limited to 80 visits per 6 month period)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Inpatient hospice</b> (Limited to 30 days per calendar year)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital emergency room services**</b>		
<ul style="list-style-type: none"> <li>• <b>Emergency room facility</b></li> </ul>	Subject to deductible until satisfied, then subject to 10% coinsurance after \$100 copayment	Subject to deductible until satisfied, then subject to 10% coinsurance after \$100 copayment
<ul style="list-style-type: none"> <li>• <b>Other emergency room services</b></li> </ul>	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
<b>Hospital inpatient services**</b> (Including semi-private or special care room, operating room, ancillary services and supplies. Pre-certification required.)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital outpatient and surgical center services</b> (Not including emergency room)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Maternity services</b>		
<ul style="list-style-type: none"> <li>• <b>Hospital services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Physician services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance



<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<b>Mental health and substance abuse services</b>		
<ul style="list-style-type: none"> <li><b>Inpatient care**</b> (Pre-certification required)</li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Outpatient care</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Transitional care</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Office visit</b> (Includes chiropractic office visit)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient laboratory Services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient radiology Services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient therapy services</b> (Limited to 15 visits combined per disability, additional visits beyond 15 require pre-certification)		
<ul style="list-style-type: none"> <li><b>Occupational therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Physical therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Speech therapy</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Physician services</b>		
<ul style="list-style-type: none"> <li><b>Hospital services</b></li> </ul>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Other services in an office</b></li> </ul>	Subject to deductible and coinsurance  (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance



Your Benefits	In network	Out of network
<b>Preventive benefit</b>		
<ul style="list-style-type: none"> <li>• <b>Comprehensive physical examination</b> (complete physical)               <ul style="list-style-type: none"> <li>~ Well-baby care</li> <li>~ Well-child care</li> <li>~ Adolescent well-care</li> <li>~ Adult well-care</li> </ul> </li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Gynecological examination for women</b> (breast exam and pelvic exam)</li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Digital prostate examination for men</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Comprehensive preventive vision examination</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Mammogram to screen for breast cancer</b> (includes 3D mammogram)</li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Pap smear to screen for cervical cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Colonoscopy screening for colorectal cancer</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Other screenings for colorectal cancer</b> <ul style="list-style-type: none"> <li>~ Sigmoidoscopy</li> <li>~ Double contrast barium enema</li> <li>~ Fecal occult blood testing</li> </ul> </li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Screening laboratory services</b> Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.</li> </ul>	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li>• <b>Bone mineral density (dexa scan) to screen for osteoporosis in women</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance



<b>Your Benefits</b>	<b>In network</b>	<b>Out of network</b>
<ul style="list-style-type: none"> <li><b>Chlamydia screening for women</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Ultrasound to screen for an abdominal aortic aneurysm</b></li> </ul>	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Immunizations and vaccinations</b> (including those needed for travel)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Flu vaccine</b> (including FluMist)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<ul style="list-style-type: none"> <li><b>Preventive dental care for children up to age 19</b> (Includes oral exam, prophylaxis, and fluoride treatment. Services limited to once every 180 days)</li> </ul>	Covered at 100%	Subject to deductible and coinsurance
<b>Skilled nursing facility</b> (Limited to 100 days per disability)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Surgical services</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Temporomandibular joint disorders or TMJ nonsurgical treatment</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Transplant services</b>		
<ul style="list-style-type: none"> <li><b>Organ Procurement and acquisition</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Transplant procedure</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Transportation and lodging</b></li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Private duty nursing</b> (Limited to \$10,000 per transplant)</li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<ul style="list-style-type: none"> <li><b>Ambulance service</b> (Limited to \$2,000 per transplant)</li> </ul>	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
<b>Vision examinations</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>All other covered</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance



**\*\* Case Management Requirement**

Participation in case management is mandatory. When a bill for hospitalization or ER occurs subsequent to a contact/offer from a SAS Case Manager that is declined, the first \$300 will not be considered for benefit payments. The balance would be considered subject to plan provisions.

**Note:**

Services received at VA facilities will be payable at the in-network level of benefits. UCR does not apply.

**Precertification Required**

Contact Hines and Associates at 800.483.5984 or [www.precertcare.com](http://www.precertcare.com)

- All Inpatient hospitalizations
- Skilled Nursing Facility and Residential Stays
- Transplants
- Physical, Occupational, and Speech therapy after 15 visits per calendar year
- Second Surgical Opinions
- Outpatient surgery including:
  - Abdominoplasty
  - Carpel Tunnel Release
  - Cosmetic/Reconstructive Surgery
  - Hip Replacement
  - Infuse Bone Graft
  - Knee Replacement
  - Panniculectomy
  - Port Wine Stain – Abnormal Vascular Lesion Treatment
  - Reduction Mammoplasty
  - Rhinoplasty
  - Septoplasty
  - Spinal Cord Stimulator

**Pharmacy**

Generic, Brand Name – No Generic Equivalent, and Brand Name

Subject to deductible and coinsurance.

Limited to a 100 day supply.

100% coverage for Preventive Drugs (not subject to deductible). Please refer to the Preventive Medication List at [www.sastpa.com](http://www.sastpa.com) for a list of covered products.

If you use a non-participating pharmacy, you will need to pay for the prescription upfront and submit a claim reimbursement form with a receipt to Security Administrative Services for reimbursement.



**Security**  
Administrative  
Services

City of Stevens Point  
MED1 & MED5  
Effective Date: January 1, 2017  
Benefit Year: January-December  
Non-Grandfathered Plan

	Reimbursement for covered prescription products will be based on the lowest contracted amount of a participating pharmacy minus any applicable deductible and/or copayment shown in this schedule.
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