Security Administrative Services

City of Stevens Point
MED2 & MED6
Effective Date: January 1, 2017
Benefit Year: January-December
Non-Grandfathered Plan

SCHEDULE OF BENEFITS
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.

Your Responsibilities	In network	Out of network
Deductible*	$1,500 individual $3,000 family	$2,500 individual $5,000 family
Coinsurance*	10%	30%
Annual Coinsurance Limit	$1,000 individual $2,000 family	$2,500 individual $5,000 family
Annual Deductible and Coinsurance Limit	$2,500 individual $5,000 family	$5,000 individual $10,000 family
Out of Pocket Maximum (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 **one** family member. The deductible must be satisfied before the plan will make any payment for services (other than preventive services).		

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

Your Benefits	In network	Out of network
Durable medical equipment and medical supplies (Including insulin pump and supplies)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hearing aids and implantable hearing devices (Limited to children up to age 18)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home health care (Limited to 100 visits per 12 month period)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospice care	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Home hospice** (Limited to 80 visits per 6 month period)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Inpatient hospice** (Limited to 30 days per calendar year)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospital emergency room services**		
• **Emergency room facility**	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
• **Other emergency room services**	Subject to deductible and coinsurance	Subject to in-network deductible and coinsurance
Hospital inpatient services** (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
Hospital outpatient and surgical center services (Not including emergency room)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Maternity services		
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Mental health and substance abuse services		
• **Inpatient care**** (Pre-certification required)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Outpatient care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Transitional care**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Office visit (Includes chiropractic office visit)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient laboratory Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient radiology Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Outpatient therapy services (Limited to 15 visits combined per disability, additional visits beyond 15 require pre-certification)		
• **Occupational therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Physician services		
• **Hospital services**	Subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible and coinsurance (Preventive immunizations covered at 100%)	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Preventive benefit		
• **Comprehensive physical examination** (complete physical) ~ Well-baby care ~ Well-child care ~ Adolescent well-care ~ Adult well-care	Covered at 100%	Subject to deductible and coinsurance
• **Gynecological examination for women** (breast exam and pelvic exam)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Digital prostate examination for men**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Comprehensive preventive vision examination**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Mammogram to screen for breast cancer** (includes 3D mammogram)	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Pap smear to screen for cervical cancer**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Colonoscopy screening for colorectal cancer**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Other screenings for colorectal cancer** ~ Sigmoidoscopy ~ Double contrast barium enema ~ Fecal occult blood testing	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Screening laboratory services** 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.	Each laboratory service covered at 1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Bone mineral density (dexa scan) to screen for osteoporosis in women**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
• **Chlamydia screening for women**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Ultrasound to screen for an abdominal aortic aneurysm**	1 per calendar year then subject to deductible and coinsurance	Subject to deductible and coinsurance
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%	Subject to deductible and coinsurance
• **Flu vaccine** (including FluMist)	Covered at 100%	Subject to deductible and coinsurance
• **Preventive dental care for children up to age 19** (Includes oral exam, prophylaxis, and fluoride treatment. Services limited to once every 180 days)	Covered at 100%	Subject to deductible and coinsurance
Skilled nursing facility (Limited to 100 days per disability)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Surgical services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Temporomandibular joint disorders or TMJ nonsurgical treatment	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Transplant services		
• **Organ Procurement and acquisition**	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• **Transplant procedure**	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• **Transportation and lodging**	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• **Private duty nursing** (Limited to $10,000 per transplant)	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
• **Ambulance service** (Limited to $2,000 per transplant)	Subject to deductible then covered at 100%	Subject to deductible then covered at 100%
Vision examinations	Subject to deductible and coinsurance	Subject to deductible and coinsurance
All other covered	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

- 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 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.

	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.