City of Maumee - 2019 Employee Health Savings Account Plan

Medical Benefits

	High Deductible HSA In-Network Provider	High Deductible HSA Out-of-Network Provider
Deductible		
Per Individual	$3,000	$5,000
Per Family	$6,000	$10,000
Co-Insurance Percentage	100%	60%
Out-of-Pocket Maximum		
Per Individual	$3,000	$7,500
Per Family	$6,000	$15,000
Medical Benefits	100% after deductible	60% after deductible
	Preventive Care	
Routine Well Adult Care	100% Includes - Office visit, pap smear, prostate screening, gynecological exam, routine physical examination, and sigmoidoscopy.	60% after deductible is met. 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.	60% 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.	60% after deductible is met. Limited to 1 per year and to age 50 and over.
Routine Well Newborn Care	100% Birth to age 24 months Includes - Office visits, routine physical examination, hearing tests, vision and immunizations.	60% after deductible. Birth to age 24 months Includes - Office visits, routine physical examination, hearing tests, vision and immunizations.
Routine Well Child Care	100% Includes - Office visits, routine physical examination, hearing tests, vision and immunizations through age 18.	60% after deductible. Includes - Office visits, routine physical examination, hearing tests, vision and immunizations through age 18.

Medical Benefits

	In-Network	Out-of-Network
	Deductible (Employee pays first).	**Deductible** (Employee pays first).
Per Person	$3,000	$5,000
Per Family	$6,000	$10,000
		Co-Insurance (40% of the charges for service)
		$2,500
		$5,000
		Max Out-of-Pocket (Deductible + CoInsurance)
		$7,500
		$15,000
Ambulance	100% after deductible is met.	80% after deductible is met.
Inpatient Hospital	100% after deductible is met.	60% after deductible is met.
Surgery	100% after deductible is met.	60% after deductible is met.
Skilled Nursing Facility	100% after deductible is met of the facility's semiprivate room rate within 3 days of a 3 day hospital stay. 100 days calendar maximum	60% after deductible is met of the facility's semiprivate room rate within 3 days of a 3 day hospital stay. 100 days calendar maximum
CT Scan, PET Scan, MRI (and inpatient x-rays and laboratory testing)	100% after deductible is met.	60% after deductible is met.
Physical Therapy, Occupational Therapy and Speech Therapy	100% after deductible is met. Maximum 30 total combined sessions per year.	60% after deductible is met. Maximum 30 total combined sessions per year.
Chiropractic	100% after deductible is met. Maximum 25 visits per year.	60% after deductible is met. Maximum 25 visits per year.
Durable Medical Equipment	100% after deductible is met.	60% after deductible is met.
Organ Transplants	100% after deductible is met.	60% after deductible is met.
Pregnancy	100%after deductible is met.	60% 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 A (Preventive - such as routine exams and x-rays): No deductible, covered 100%.
Class B (Basic - such as fillings and root canals): covered 80% after $50 per person annual deductible.
Class C (Major - such as crowns and bridges): covered 50% after $50 per person annual deductible.
Orthodontia is covered 60% (no deductible) $1,500 lifetime maximum per eligible dependent to age 19.

Prescription Drug Benefits

	Retail	Mail Order
	30-day supply	90-day supply
Generic	100% after deductible met	100% after deductible met
Preferred ("Formulary") Brand	100% after deductible met	100% after deductible met
Non-Preferred Brand	100% after deductible met	100% after deductible met
	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 visions, lined bifocal, lined trifocal, tinted, and photochromic lenses.
Frame	$25 for exam and/or eyewear	New frames (with a $130 allowance + 20% discount over allowance) every 12 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.