THT Plan Designs

	2016		
	Services Provided Within the Medical Home	**Services Provided Outside the Medical Home (Preferred Provider)**	**Services Provided by Out of Network Providers**
Calendar Year Deductible - Per individual per year	None	$600	$2,500
Deductible $ Limit per Family per Year	Not Applicable	3 X Limit	4 X Limit
Out-of-Pocket Maximum - Applies to cost sharing on all services provided in Medical Home or within the Preferred Provider network, True ER from Non-Network, and includes copays from Rx Plan	$6,600 Individual		None
Total Out of Pocket Maximum per Family (Medical Home and Preferred Provider is a combined total)	$13,200 Family		None
Preventive Care	$0 co-pay	Not Covered	Not Covered
Primary Care Physician Office Visit	$10 co-pay	20% co-insurance after deductible	40% co-insurance after deductible
Specialist Physician - consult or office visit	$20 co-pay with referral	20% co-insurance after deductible	40% co-insurance after deductible
Specialist Physician - consult or office visit without referral	20% co-insurance after deductible		40% co-insurance after deductible
Medical Home Identified Chronic Condition Patients - Primary Care or Specialist Physician Office visit	$0 co-pay	N/A	N/A
Office Surgery	20% coinsurance (ded does not apply if at MH provider and in conjunction with a MH visit, otherwise, deductible applies)	20% co-insurance after deductible	40% co-insurance after deductible
Obstetrics (full pregnancy/delivery care bundle) - Normal Pregnancy/ Not MH identified as High Risk	$10 copay for office visits, 20% co-insurance for Delivery Package (ded does not apply)	20% co-insurance after deductible	40% co-insurance after deductible
Obstetrics (full pregnancy/delivery care bundle) - pregnancies identified as High Risk by MH and enrolled and compliant in that MH extension	$0 copay for office visits, 20% co-insurance for Delivery Package (ded does not apply)	20% co-insurance after deductible	40% co-insurance after deductible

THT Plan Designs

	Services Provided Within the Medical Home	Services Provided Outside the Medical Home (Preferred Provider)	Services Provided by Out of Network Providers
Anesthesia	20% co-insurance after deductible		40% co-insurance after deductible
Facility (Inpatient, outpatient, or ASC facility services)	$400 per day $800 Max per stay (first day copay also applies to outpatient service or ASC episode)		40% co-insurance after deductible
SNF/Home Health/DME	20% co-insurance (ded does not apply)		40% co-insurance after deductible
Ambulance	20% co-insurance (ded does not apply)		20% co-insurance (ded does not apply)
Urgent Care	$50 co-pay		40% co-insurance (ded does not apply)
Minute Clinics	$15 co-pay		Not Covered
Emergency Room - True Emergency	$250 True Emergency		$250 True Emergency
Emergency Room - Non-emergency	$400 non-emergency		$400 non-emergency
Laboratory	$0 co-pay Quest		40% co-insurance after deductible
Routine X-Rays	$0 co-pay at Steinberg		40% co-insurance after deductible
CAT Scan	$50 at Steinberg		40% co-insurance after deductible
MRI	$75 at Steinberg		40% co-insurance after deductible
PET Scan	$200 at Steinberg		40% co-insurance after deductible

THT Plan Designs

	CURRENT PLAN (Effective 7/23/15)		
	Diamond PPO	**Platinum PPO**	**Retiree PPO**
Calendar Year Deductible - Per individual per year	$0	$0	$0
Deductible $ Limit per Family per Year	N/A	N/A	N/A
Out-of-Pocket Maximum - Applies to cost sharing on all services provided in Medical Home or within the Preferred Provider network, True ER from Non-Network, and includes copays from Rx Plan	$6,600 Individual	$6,600 Individual	$6,600 Individual
Total Out of Pocket Maximum per Family (Medical Home and Preferred Provider is a combined total)	$13,200 Family	$13,200 Family	$13,200 Family
Preventive Care	$0 co-pay	$0 co-pay	$0 co-pay
Primary Care Physician Office Visit	$20 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance
Specialist Physician - consult or office visit	$20 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance
Specialist Physician - consult or office visit without referral	$20 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance
Medical Home Identified Chronic Condition Patients - Primary Care or Specialist Physician Office visit	N/A	N/A	N/A
Office Surgery	$20 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance
Obstetrics (full pregnancy/delivery care bundle) - Normal Pregnancy/ Not MH identified as High Risk	$150 co-pay + 20% coinsurance	$300 co-pay + 20% coinsurance	$300 co-pay + 20% coinsurance
Obstetrics (full pregnancy/delivery care bundle) - pregnancies identified as High Risk by MH and enrolled and compliant in that MH extension	$150 co-pay + 20% coinsurance	$300 co-pay + 20% coinsurance	$300 co-pay + 20% coinsurance

THT Plan Designs

	Diamond PPO	Platinum PPO	Retiree PPO
Anesthesia	$100 co-pay + 20% coinsurance	$150 co-pay + 20% coinsurance	$150 co-pay + 20% coinsurance
Facility (Inpatient, outpatient, or ASC facility services)	$150 per day, $450 Max per admission + 20% coinsurance	$300 per day, $900 Max per admission + 20% coinsurance	$300 per day, $900 Max per admission + 20% coinsurance
SNF/Home Health/DME	$150 per day, $450 Max per admission + 20% coinsurance	$300 per day, $900 Max per admission + 20% coinsurance	$300 per day, $900 Max per admission + 20% coinsurance
Ambulance	20% coinsurance	30% coinsurance	20% coinsurance
Urgent Care	$20 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance	$30 co-pay + 20% coinsurance
Minute Clinics	N/A	N/A	N/A
Emergency Room - True Emergency	$150 co-pay + 20% coinsurance	$300 co-pay + 20% coinsurance	$300 co-pay + 20% coinsurance
Emergency Room - Non-emergency	$250 co-pay + 20% coinsurance	$400 co-pay + 20% coinsurance	$400 co-pay + 20% coinsurance
Laboratory	$0 co-pay at Quest	$0 co-pay at Quest	$0 co-pay at Quest
Routine X-Rays	$10 co-pay + 20% coinsurance	$20 co-pay + 20% coinsurance	$20 co-pay 20% coinsurance
CAT Scan	$50 co-pay + 20% coinsurance	$75 co-pay + 20% coinsurance	$75 co-pay + 20% coinsurance
MRI	$50 co-pay + 20% coinsurance	$75 co-pay + 20% coinsurance	$75 co-pay + 20% coinsurance
PET Scan	$200 co-pay + 20% coinsurance	$400 co-pay + 20% coinsurance	$400 co-pay + 20% coinsurance