Medical Benefits

Claims Administrator: UMR, Inc. (877) 840-5583 (www.umr.com)

Care System: Sioux Empire Health Care Coalition (Tiers 1 & 2)

- Sanford (Sioux Valley Hospital) (800) 805-7938
- Avera Tri State (McKennan Hospital) (888) 605-1331
- PHCS (Tier 3) (800) 678-PHCS

Pharmacy Network: Prescription Solutions

Monthly Costs[1]:

		Standard Rates		Wellness Rates[2]		Total
Coverage	Coverage Tier	Staff Cost	Employer Cost	Staff Cost	Employer Cost	Plan Cost
Individual Coverage	Avera/Sanford	$89.44	$310.73	$70.94	$329.23	$400.17
	PHCS	$98.39	$341.81	$78.04	$362.17	$440.20
Individual + 1 Coverage	Avera/Sanford	$196.77	$683.61	$156.07	$724.31	$880.38
	PHCS	$216.45	$751.97	$171.67	$796.77	$968.42
Family Coverage	Avera/Sanford	$286.20	$994.36	$227.00	$1,053.56	$1,280.56
	PHCS	$314.83	$1,093.75	$249.71	$1,158.92	$1,408.58

[1]Based on Full-time schedule. Part-time staff premiums are proportionally adjusted based on work schedule. Premiums for Part-time staff can be found in the back of this booklet.

[2]New employees receive the Wellness Rate. Employees hired on or after November 1, 2012, will receive the Wellness Rate (reduced medical insurance premiums) for the remainder of the 2012-13 plan year and the 2013-14 plan year without completing the Quality Health Survey or Preventive Care Form requirements. However, in order to retain the Wellness Rate for the 2014-15 plan year, these employees must complete the Wellness Program requirements by March 1, 2014.

Summary of Medical Benefits

SERVICE	PARTICIPATING PROVIDERS Member pays	NON-PARTICIPATING PROVIDERS Member pays
Provider Networks	When services are provided by your designated Care System, the provider will file claims on your behalf and has agreed to the allowed amount payment as payment in full less your deductible or copayments.	You still receive benefits when you use a non-participating provider, however, you may be responsible for filing your claims and payment to the provider. Any difference between the billed charge and the allowed amount is your responsibility. In addition, you are responsible for obtaining preadmission notification for inpatient hospital admissions and prior authorization for certain medical procedures.
Annual Benefit Maximum	$2,000,000 (combined)	
Lifetime Benefit Maximum	Unlimited	
Deductible (Per Plan Year)		
▪ Individual	$500	$1,500
▪ Family	$1,000	$3,000
Annual Out-of-pocket Maximum		
▪ Individual	$2,500	$5,000
▪ Family	$5,000	$10,000

SERVICE	PARTICIPATING PROVIDERS Member pays	NON-PARTICIPATING PROVIDERS Member pays
Services Received in a Physician's Office:		
Office Visits for illness or injuries		
▪ Physician	$20 co-pay per visit	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
▪ Specialist	$20 co-pay per visit	
Physician Office Services *(laboratory, x-ray, therapy services, surgical procedures, etc.)*	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
***Preventive Care** (unlimited)*		
▪ *Routine physicals*	Nothing	Not covered
▪ Routine Cancer Screening (Maximum 1 Exam/Plan Year)	Nothing	Not covered
▪ Mammograms, Pap Smears and Breast Exams for women, Prostate/PSA Exams for men	Nothing	Not covered
▪ Routine Preventive Health Screening Tests, Lab and X-rays		
▪ Immunizations	Nothing (excluding flumist and lyme disease vaccine)	Not covered
▪ Well Child Care Visits (birth to age 6)	Nothing	Not covered
▪ Routine Hearing Exams	Nothing	Not covered
Preventive Colonoscopy, Sigmoidoscopy, and similar routine diagnostic procedures	Nothing	Not covered
Therapy Services:		
• Physical, Speech and Occupational Therapy (Physician's Office)	• $20 co-pay per visit	40 % after the deductible up to the out-of-pocket maximum, then plan pays 100%.
• Physical, Speech and Occupational Therapy (Outpatient Hospital)	• 20% after the deductible up to the out-of-pocket maximum, then plan pays 100%	40 % after the deductible up to the out-of-pocket maximum, then plan pays 100%.
• Chiropractic Care	• 20% after the deductible up to the out-of-pocket maximum, then plan pays 100%	40 % after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Outpatient Services Received in a Hospital or Other Outpatient Setting:		
Outpatient Hospital Services (Lab tests, x-rays, kidney dialysis, radiation or chemotherapy, surgery, etc.)	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Outpatient Mental Health and Chemical Dependency Care	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Emergency Room Services	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	Coverage is provided at the in-network level for *emergency services*
Physician services for outpatient surgery, anesthesia, obstetrics and in-hospital medical visits	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Inpatient Hospital Care (semi-private room):		
Inpatient Hospital Services (room and board, lab tests, x-rays, medication and medical supplies)	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%. ***Preadmission Notification required** or you may be responsible for an additional portion of the bill.*

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Inpatient Mental Health and Chemical Dependency Care	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%. ***Preadmission Notification required*** *or you may be responsible for an additional portion of the bill.*
Physician services	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Transplant Services	At Designated Transplant Facility (URN or Avera/McKennan Hospital/University Health Center): Nothing At another Network Facility: 40% of total cost (deductible waived)	40% (deductible waived)
Other Medical Services:		
Durable Medical Equipment and Supplies *(Limitations may apply)*	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Ambulance Service	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Home Health Care *(40 visits/plan year maximum)*	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Skilled Nursing Care (60 days/plan year maximum)	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Hospice Care (Lifetime maximum: Lesser of 6 months or $10,000)	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Prescription Drug Benefit:		
At designated retail pharmacies You pay your co-pay at time of purchase. *(Your co-pay applies to a maximum 30-day or 100-unit supply; insulin and diabetic supplies are covered.)*	• Over-the-counter non-sedating antihistamines [Alavert, loratadine (generic Claritin), cetirazine (generic Zyrtec)] and ulcer drugs (Prilosec OTC) - $0 copay with physician's prescription • Over-the-counter aspirin to prevent cardiovascular disease, iron supplements to prevent anemia, fluoride tablets for children, erythromycin ophthalmic ointment for newborns, with physician's prescription • Generic Anti-Cholesterol [lovastatin (generic Mevacor), pravastatin (generic Pravachol), simvastatin (generic Zocor)] and Ulcer [omeprazole (generic Prilosec)] medications - $0 copay • *For Disease Management Program Participants ONLY*: Diabetic supplies, Generic endocrine and metabolic drugs (insulin) and Generic anti-hypertensive (high blood pressure) medicines - $0 copay • Other Generic Products: Greater of $7/prescription or 10% • Preferred Brand Products: Greater of $25/prescription or 25% (Maximum $100) • Non-Preferred Brand Products: Greater of $50/prescription or 40% (Maximum $200) • If you choose to take a brand-name drug when a generic equivalent is available, you pay the brand-name copay plus the difference in cost between the brand and generic medication.	
Mail pharmacy You can receive a 90-day supply of medications *through the Mail Order program*.	• Generic Products: Greater of $17.50/prescription or 10% • Preferred Brand: Greater of $62.50/Prescription or 25% (Maximum $250) • Non-Preferred Brand: Greater of $125/Prescription or 40% (Maximum $500)	N/A
Specialty Medications *(From Specialty Pharmacy Vendor. Co-pay applies to a 30-day supply)*	• 25% of the cost of the drug to a maximum of $150/prescription	N/A