

**Cole County Commission
2021 Summary of Benefits**



	High Deductible Health Plan with H S A		Traditional PPO Plan	
	In-Network	Out-of-network	In-Network	Out-of-network
Deductible (Member Pays)				
Individual	\$2,500	\$4,500	\$1,000	\$2,000
Family	\$5,000	\$9,000	\$2,000	\$4,000
Coinsurance (Plan Pays after Deductible)	100%	80%	80%	60%
Out of Pocket Maximum (Employee Pays)				
Individual HDHP H.S.A.	\$4,500	Unlimited		
Family HDHP H.S.A.	\$9,000*	Unlimited		
Trad PPO Individual Medical			\$3,000	Unlimited
Trad PPO Individual Pharmacy Copays Only			\$4,150	Unlimited
Trad PPO Family Medical			\$6,000	Unlimited
Trad PPO Family Pharmacy Copays Only			\$8,300	Unlimited
	*\$6,550 Embedded for Ind. on Family Plan			
All benefits are subject to the deductible unless otherwise stated				
Preventive Care- Ded. & co-pay waived in network <i>only</i>)				
Primary Care Office Visit	Deductible	Ded. + Coins.	\$30 co-pay	Ded. + Coins.
Specialist Office Visit	Deductible	Ded. + Coins.	\$60 co-pay	Ded. + Coins.
TELADOC - VIRTUAL VISIT	\$45	N/A	\$20	N/A
Outpatient Facility covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Outpatient Lab & X-ray covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Outpatient Physicians covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Outpatient Surgery covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Inpatient Facility covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Inpatient Lab & X-ray covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Inpatient Physicians & Surgeons covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Inpatient Surgery covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Durable Medical Equipment covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Emergency Room covered at:	Deductible	Ded. + Coins.	\$300 co-pay	\$300 co-pay
Urgent Care covered at:	Deductible	Ded. + Coins.	\$50 co-pay	Ded. + Coins.
Extended Care Facility covered at: (to a 60 day maximum per calendar year)	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Chiropractic Services covered at:	Deductible	Ded. + Coins.	Office Visit co-pay	Ded. + Coins.
Hearing Aids Max of \$2500 a calendar year covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Home Health Care covered at: (to a maximum of 60 days per calendar year)	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Transplant Services covered at:	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Therapies covered at: (Physical, Occupational, Speech, Pulmonary, Cognitive, Cardiac etc) 20 visits max per therapy combined in or out of network	Deductible	Ded. + Coins.	Ded. + Coins.	Ded. + Coins.
Routine Vision Exam 1 every 2 years	Deductible	Ded. + Coins.	Copay	Ded. + Coins.
Prescription Coverage	Co-pays apply AFTER DEDUCTIBLE has been met			
Retail (up to a 30 day supply) Generic/Preferred/NonPreferred	Tiers 1,2,3 - 10% of cost per fill Specialty 25%		Tiers 1,2,3 - 10% of cost per fill Specialty 25%	
Mail Order (up to a 90 day supply) Generic/Preferred/NonPreferred	Tiers 1,2,3 - 10% of cost X 2.5 Specialty 25%		Tiers 1,2,3 - 10% of cost X 2.5 Specialty 25%	
Retail 90 Day Fills	90 Day Fills May be Acquired at Some Local Pharmacies at 3X retail copay			
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

All benefits are subject to Medical Necessity. This document is a summary of benefits. For more detailed information please refer to The Summary Plan Document.
The plan document supercedes this short summary.

Measurement Period Determination is Made by a Counting Period Basis of 12 Months and Not on a Week to Week Basis.