



# Benefit Selection Report

Prospect

City of Mount Vernon

Effective Date: 01/01/2016

Product Name: Your Choice (Copay) NGE	Specifications and Benefit Limits	Heritage In-Network	Heritage Out-of-Network
Plan Name: Opt 3 LEOFF YC \$0 0-50% \$375 \$20 Copay			
<b>MEDICAL COST SHARE OPTIONS</b>			
Personal Funding Pricing	Price Standalone		
Individual Deductible PCY	No Family deductible	\$0 PCY	Shared with In-Network
Fourth Quarter Deductible Carryover	No		
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		0%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable	Family embedded OOP max 2X Individual	\$375 PCY	Shared with In-Network
Office Visit Cost Share		\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Annual Plan Maximum		Unlimited	Unlimited
<b>FACILITY CARE</b>			
Inpatient Facility		In Network Deductible, then 0%	Out of Network Deductible, then 50%
Outpatient Surgery Facility		In Network Deductible, then 0%	Out of Network Deductible, then 50%
Outpatient Facility		In Network Deductible, then 0%	Out of Network Deductible, then 50%
Skilled Nursing Facility	60 days PCY	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Hospice Inpatient Facility	10 days Inpatient; within the 6 month lifetime maximum	In Network Deductible, then 0%	Out of Network Deductible, then 50%
<b>EMERGENCY CARE AND TRANSPORTATION</b>			
Emergency Care (Waive copay if admitted to inpatient facility)		In Network Deductible, then 0%	In Network Deductible, then 0%
Emergency Room Physician		In Network Deductible, then 0%	In Network Deductible, then 0%
Ambulance Transportation	Unlimited	In Network Deductible, then 0%	In Network Deductible, then 0%
Air Ambulance	Unlimited	In Network Deductible, then 0%	In Network Deductible, then 0%
<b>DIAGNOSTIC SERVICES</b>			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered In Full	Out of Network Deductible, then 50%
Preventive Mammography		Covered In Full	Out of Network Deductible, then 50%
Other Professional Diagnostic Imaging		Covered In Full	Out of Network Deductible, then 50%
Diagnostic Mammography		Covered In Full	Out of Network Deductible, then 50%
Other Professional Diagnostic Laboratory/Pathology		Covered In Full	Out of Network Deductible, then 50%
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>			
Preventive Office Visit	Unlimited	Covered In Full	Not Covered
Immunizations	Unlimited	Covered In Full	Not Covered
Preventive Colon Health		Covered In Full	Out of Network Deductible, then 50%
Health Education (HE)	Unlimited	Covered In Full	Not Covered
Community Wellness, Prevention & Safety Programs (CW)	Not Covered	Not Covered	Not Covered
Nicotine Dependency Programs (ND)	Unlimited	Covered In Full	Not Covered
Diabetes Health Education (DE)	Unlimited	Covered In Full	Not Covered
<b>PROFESSIONAL CARE</b>			
Professional Office Visit including Urgent Care		\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Telehealth Virtual Care	With Vendor	\$20 Copay, applies to the Out of	Out of Network Deductible,

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		Pocket Maximum	then 50%
Inpatient Professional Services		In Network Deductible, then 0%	Out of Network Deductible, then 50%
Contraceptive Management	Unlimited	Covered In Full	Out of Network Deductible, then 50%
Maternity Prenatal, Delivery and Postnatal Care	Coverage for subscriber, spouse, dependent	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Sterilization - Female	Unlimited	Covered In Full	Out of Network Deductible, then 50%
Sterilization - Male	Unlimited	In Network Deductible, then 0%	Out of Network Deductible, then 50%
<b>OTHER SERVICES</b>			
Infertility	Not Covered	Not Covered	Not Covered
Mental Health Inpatient Facility Care	Unlimited	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Mental Health Outpatient Facility Care	Unlimited	Covered In Full	Out of Network Deductible, then 50%
Mental Health Outpatient Professional Care	Unlimited	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Mental Health Residential Care (groups effective 7/1/2014 and after)		In Network Deductible, then 0%	Out of Network Deductible, then 50%
Acupuncture	12 visits PCY	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Manipulations (Spinal and other)	Unlimited	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Naturopathy Services	Unlimited	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neuro dev & Mental Health) (groups effective 7/1/2014 and after, no limit)	Unlimited	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Rehab Inpatient Facility	60 days PCY	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy	60 visits PCY	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer		\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)	MS: Unlimited, ME: Unlimited, Pro: Unlimited	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Foot Orthotics, Orthopedic Shoes and Accessories	\$300 PCY (Unlimited Diabetes Related)	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Chemical Dependency Inpatient Facility Care	Unlimited	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Chemical Dependency Outpatient Facility Care	Unlimited	Covered In Full	Out of Network Deductible, then 50%
Chemical Dependency Outpatient Professional Care	Unlimited	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Home Health Care	130 visits PCY	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Hospice Care	Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum	In Network Deductible, then 0%	Out of Network Deductible, then 50%
Transplants	Unlimited; \$7,500 travel and lodging limits	Covered as any other service	Not Covered
TMJ (Temporomandibular Joint Disorders)	Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)	Covered as any other service	Covered as any other service
Orthognathic/Maxillofacial Care	Included in the \$5,000 lifetime max	Office visits: \$20 Copay; Inpatient and Outpatient Hospital: Covered as any other service	Covered as any other service
Allergy/Therapeutic Injections		Covered In Full	Out of Network Deductible, then 50%

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End-Stage Renal Disease (ESRD), first 90 days of dialysis or until Medicare effective date		Subject to Deductible, then Coinsurance	Subject to OON Deductible, then OON Coinsurance
End-Stage Renal Disease (ESRD), 91st day and after or Medicare effective date up to 30 months	With Premium Reimbursement	Waive Deductible, 0% (Covered in full)	Waive Deductible, 0% (Covered in full)
<b>SUPPLEMENTAL BENEFITS</b>			
Routine Vision Exam	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam	Not Covered	Not Covered	Not Covered
Pediatric Vision Hardware	Not Covered	Not Covered	Not Covered
Routine Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Hardware	Not Covered	Not Covered	Not Covered
<b>ADMINISTRATIVE OPTIONS</b>			
BlueCard/National Coverage Program	Plus 1 (Default) In-network and Out of network PPO network		
Obstetrical Care for Dependent Daughters	Yes		

## COVERAGE SELECTIONS AGREEMENT

I affirm that the coverage selections and corresponding rates are correct and I am authorized to sign on behalf of the group.

Signature of Group's Representative

Date

Group's Representative (*Print Name*)

Title

Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.