McLennan County Employee Health Plan
2015 - 2016

Effective October 1, 2015	Plan 1 Base Plan - $1000 Deductible Plan	Plan 2 Consumer Driven Health Plan
Annual Deductible	$1,000 Individual	$3,500 Individual
(Deductible applies to Out-of-Pocket Max & **resets to zero Jan. 1st**)	$2,000 Family	$7,000 Family (Embedded)
Annual Out-of-Pocket Maximum	$4,500 Individual	$3,500 Individual
(Medical & Rx deductibles both apply)	$9,000 Family	$7,000 Family (Embedded)
Outpatient Services		
Primary Care Office Visit	$30 Copay	$0 Copay after deductible
Specialty Care Office Visit	$50 Copay	$0 Copay after deductible
Preventive Services (including lab and x-ray)	No Charge	No Charge
Standard Lab and X-Ray	No Charge	0% after deductible
Diagnostic/Radiology (Limited to: angiograms, CT scans, MRIs, PET scans, myelography, stress tests, ultrasound)	20% After Deductible	0% after deductible
Outpatient Surgery	20% After Deductible	0% after deductible
Allergy Serum	20 % After Deductible	0% after deductible
Immunizations (Age appropriate)	No Charge	No Charge
Eye Exam (1 refraction annually)	$30 Copay	0% after deductible
Maternity (Pre- and Post-Natal Care)	No Charge	No Charge
Other Outpatient Services **(Including other services, treatments, or procedures received at time of visit)**	20% after deductible	0% after deductible
Outpatient Specialty Drugs (Deductible does not apply)		
Level 1	10% Copay	0% after deductible
Level 2 (Preferred)	20% Copay	0% after deductible
Level 3 (Premium Preferred)	30% Copay	0% after deductible
Level 4 (Non-Preferred)	50% of charges	0% after deductible
Inpatient Services		
Hospital Room, Semi-private	20 % After Deductible	0% after deductible
Intensive Care Unit	20 % After Deductible	0% after deductible
Other Hospital Services	20 % After Deductible	0% after deductible
Skilled Nursing Facility (Pre-Certification Required)	20% After Deductible	0% after deductible (Pre Certification Required)
Therapeutic Services		
Speech & Hearing	$30 Copay (20 Visit Limit)	$0 Copay after deductible
Physical Therapy	$30 Copay (20 Visit Limit)	$0 Copay after deductible
Durable Medical Equipment		
Durable Medical Equipment	50% After Deductible	$0 after deductible
Diabetic Supplies, Equipment and Self-Management Training (Unlimited Benefit) "Deductible Does Not Apply"		
Supplies	50% Copay	Same as DME or RX, asappropriate
Equipment	Same as DME or Rx, as appropriate	Same as DME or RX, as appropriate
Education/Nutrition Counseling	$30 Copay	$0 Copay after deductible
Outpatient - Mental Health/Chemical Abuse Services		
Serious Mental Illness (Requires referral and approval of medical director)	$30 Copay	$0 Copay after deductible
Alcohol and Drug Dependency	$30 Copay	$0 Copay after deductible
Inpatient - Mental Health/Chemical Abuse Services		
Serious Mental Illness (Requires referral and approval of medical director)	20% After Deductible	0% after deductible
Alcohol and Drug Dependency	20% After Deductible	0% after deductible
Home Infusion Therapy (requires authorization)		
Home Infusion Therapy	20%	0% after deductible
Home Health Services (Requires authorization)		
Home Health	$30 Copay	$0 Copay after deductible
Hospice	No Charge	0% after deductible
Emergency Care Services		
Emergency Room (In and out of area)	20% After Deductible	0% after deductible
Urgent Care (In and out of area)	$50 Copay	0% after deductible
Ambulance	20% After Deductible	0% after deductible
Prescription Drug Coverage (Can use any in-network Rx provider)		
		Copays only apply to preventive drugs (deductible does not apply) All non-preventive drugs are subject to the deductible.
Annual Benefit Maximum	Unlimited	Unlimited
Annual Deductible	None	Included with medical deductible
Retail Quantity (Up to a 30-day supply)		
Generic	$10 Copay	$10 Copay
Preferred Brand	$30 Copay	$30 Copay
Non-Preferred	Lesser of $55 or 50%	Lesser of $55 or 50%
Non-Formulary	Greater of $55 or 50%	Greater of $55 or 50%
Maintenance Quantity (Up to a 90-day supply) Maintenance quantities must be obtained from a Scott & White Health Plan pharmacy or Wal-Mart Mail Order)		
Generic	$20 Copay	$20 Copay
Preferred Brand	$60 Copay	$60 Copay
Non-Preferred	Lesser or $110 or 50%	Lesser or $110 or 50%
Non-Formulary	N/A	N/A

For more information, please refer to your Summary Plan Description.
To view a complete list of providers and other plan details, go to https://mclennan.swhp.org/.
Customer Service 800-299-8640