Madison Area Technical College
Outline of Benefits – HMO Copay Plan
Effective January 1, 2019

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Deductible		
Per Covered Person	$250	Not Applicable
Per Family	$500	Not Applicable
Coinsurance		
Coinsurance	10%	Not Applicable
Annual Out-of-Pocket Limit (includes deductible and coinsurance)		
Per Covered Person	$500	Not Applicable
Per Family	$1,000	Not Applicable
Maximum Annual Out-of-Pocket Limit (includes deductible, coinsurance & all copayments)		
Per Covered Person	$5,350	Not Applicable
Per Family	$10,700	Not Applicable
Covered Expenses (not including covered drugs and covered supplies dispenses by a pharmacy)		
PROVISION/BENEFIT	**PARTICIPATING PROVIDERS What you pay**	**NON-PARTICIPATING PROVIDERS What you pay**
Ambulance services**	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Behavioral health Therapy services Outpatient/Transitional services Inpatient services**	 0% 0% 0%	Not Covered
Chiropractic office visit/manipulations	Deductible and Coinsurance	Not Covered
Contraceptives	0%	Not Covered
Diagnostic x-ray and laboratory services (excludes high-technology imaging) – outpatient**	Coinsurance	Not Covered
Durable medical equipment**	Deductible and Coinsurance	Not Covered
Emergency room – visit charge only	$150 Copayment, then 0%	$150 Copayment, then 0%
Emergency room services	Coinsurance	Participating Provider Coinsurance
High-technology imaging	$50 Copayment, then 0%	Not Covered
Home care – limited to 40 visits per year	Deductible and Coinsurance	Not Covered
Hospital inpatient services**	Deductible and Coinsurance	Not Covered
Immunizations	0%	Not Covered
Injections - outpatient	Coinsurance	Not Covered
Kidney disease treatment	Deductible and Coinsurance	Not Covered
Maternity services	Deductible and Coinsurance	Not Covered
Medical supplies	Deductible and Coinsurance	Not Covered
Nutritional counseling	0%	Not Covered
Office visits – visit charge only Primary Care Practitioner Specialist	 $25 Copayment, then 0% $25 Copayment, then 0%	Not Covered

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Preventive care services* (includes routine eye exams for children and adults)	0%	Not Covered
Surgical services	Deductible and Coinsurance	Not Covered
Telehealth visits (through Teladoc)	$0 Copayment, then 0%	Not Covered
Therapy visits (physical/ speech/occupational) Office setting Home or outpatient hospital setting	 Deductible and Coinsurance Deductible and Coinsurance	Not Covered
Transplant services**	Deductible, then 0%	Not Covered
All other health care services – unless otherwise stated in your plan	Deductible and Coinsurance	Not Covered
Covered Drugs and Covered Supplies		
Prescription drug and certain diabetic supplies $1,500 out-of-pocket per person ***(Drugs and covered supplies dispensed by a non-participating pharmacy are not covered.)***	Dispensed by a Retail Pharmacy: Generic - $5 Copayment Preferred Brand-Name - $35 Copayment Brand-Name – $50 Copayment Specialty – $75 Copayment Oral chemotherapy drugs are limited to $100 copayment Home Delivery is 2 times the retail pharmacy copayment	
Preventive drugs: As required by the Affordable Care Act and defined in the Policy. Also includes additional preventive drugs at no cost to you (refer to $0 Drug List for details).	0% (copayment waived)	
Limitations *Maintenance medications must be purchased through home delivery, unless the member has elected to opt out of that program prior to the fourth purchase.*	Retail: 30-day supply Home Delivery: 90-day supply Specialty drugs and Chemotherapy drugs: 30-day supply Smoking Cessation – Limited to 180-day supply	
Mandatory generic & Step therapy	Applicable	
Specialty drugs**	Specialty drugs are prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost.	

This is a brief summary of benefits created from a sales quote presentation. Finalized benefits will take precedence over any benefit information presented in this outline.

* Includes preventive screenings as required by the United States Preventive Services Task Force (USPSTF)

** Some services may require prior authorization. Please go to our website arisehealthplan.com for further information.