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

PROVISION/BENEFIT	PREFERRED PROVIDERS What you pay	NON-PREFERRED PROVIDERS What you pay
Deductible		
Per Covered Person	$250	$500
Per Family	$500	$1,000
Coinsurance		
Coinsurance	10%	30%
Annual Out-of-Pocket Limit (includes deductible and coinsurance)		
Per Covered Person	$500	$1,500
Per Family	$1,000	$3,000
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	PREFERRED PROVIDERS What you pay	NON-PREFERRED PROVIDERS What you pay
Ambulance services**	Deductible and Coinsurance	Preferred Provider Deductible and Coinsurance
Behavioral health Therapy services Outpatient/Transitional services Inpatient services**	 0% 0% 0%	 0% 0% 0%
Chiropractic office visit/manipulations	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services (excludes high-technology imaging) – outpatient**	Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible and Coinsurance	Deductible and Coinsurance
Emergency room – visit charge only	$150 Copayment, then 0%	$150 Copayment, then 0%
Emergency room services	Coinsurance	Preferred Provider Coinsurance
High-technology imaging	$50 Copayment, then 0%	Deductible and Coinsurance
Home care – limited to 40 visits per year	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	0%
Injections - outpatient	Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0%	Deductible and Coinsurance
Office visits – visit charge only Primary Care Practitioner Specialist	 $25 Copayment, then 0% $25 Copayment, then 0%	 Deductible and Coinsurance Deductible and Coinsurance
Preventive care services* (includes routine eye exams for children and adults)	0%	Deductible and Coinsurance

PROVISION/BENEFIT	PREFERRED PROVIDERS What you pay	NON-PREFERRED PROVIDERS What you pay
Surgical services	Deductible and Coinsurance	Deductible and Coinsurance
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	 Deductible and Coinsurance Deductible and Coinsurance
Transplant services** Inpatient services Outpatient services	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible, 50% Coinsurance Deductible and Coinsurance
All other health care services – unless otherwise stated in your plan	Deductible and Coinsurance	Deductible and Coinsurance
Covered Drugs and Covered Supplies		
Prescription drugs and certain diabetic supplies $1,500 out-of-pocket per person	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 wpshealth.com for further information.