

Methodist Health System – January 1, 2021 Health Care Plan Options MJE

COMPARISON CHART FOR HEALTH PLAN OPTIONS	\$1,000 DEDUCTIBLE PPO PLAN			HIGH DEDUCTIBLE HEALTH PLAN		
	**IN-NETWORK BENEFITS:					
PLAN MAXIMUMS	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
*Calendar Year Deductible	\$1,000 Per Individual \$2,000 EE + 1 \$3,000 Family	\$1,000 Per Individual \$2,000 EE + 1 \$3,000 Family	\$3,000 per Individual \$5,000 EE + 1 \$7,000 Family	\$1,400 EE Only \$2,800 Two or More <i>For 2 or more Individuals covered the deductible of \$2,800, \$5,000 or \$10,000 must be satisfied before coinsurance coverage applies.</i>	\$2,500 EE Only \$5,000 Two or More	\$5,000 EE Only \$10,000 Two or More <i>No one Individual must satisfy more than \$6,900 for out-of-pocket maximum.</i>
*Out-Of-Pocket Limit	\$4,000 Per Individual \$6,500 EE + 1 \$9,000 Family	\$4,000 Per Individual \$6,500 EE + 1 \$9,000 Family	\$7,000 per Individual \$10,000 EE + 1 \$14,000 Family	\$5,000 EE Only \$10,000 Two or More	\$5,200 EE Only \$10,400 Two or More	\$6,900 EE Only \$13,800 Two or More
PHYSICIAN SERVICES	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Preventive Care Visit	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Primary Care Physician Visit	\$25 Copay	\$25 Copay	60% after Deductible	15% after Deductible	20% after Deductible	60% after Deductible
Specialist Visit	\$50 Copay	\$50 Copay	60% after Deductible	15% after Deductible	20% after Deductible	60% after Deductible
Pathology	Included in Copay	Included in Copay	60% after Deductible	15% after Deductible	20% after Deductible	60% after Deductible
All Other	15% after Deductible	20% after Deductible	60% after Deductible	15% after Deductible	20% after Deductible	60% after Deductible
TELEHEALTH SERVICES	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Teladoc & MPC Providers Only:	\$15 Copay	\$15 Copay	-----	15% after Deductible	20% after Deductible	-----
**HOSPITAL & OTHER FACILITIES	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
ER Medical Emergency	\$300 Copay then 15% after Deductible	\$300 Copay then 20% after Deductible	\$300 Copay then 20% after Deductible	15% after Deductible	20% after Deductible	20% after Deductible
ER Non-Medical Emergency	\$300 Copay then 25% after Deductible \$300 Copay waived if admitted	\$300 Copay then 30% after Deductible \$300 Copay waived if admitted	\$300 Copay then 30% after Deductible \$300 Copay waived if admitted	25% after Deductible 15% after Deductible	30% after Deductible 20% after Deductible	30% after Deductible 60% after Deductible
All Other Hospital & Facility	15% after Deductible	20% after Deductible	60% after Deductible			
MENTAL HEALTH CARE	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Office Visit/Med Check/Grp Therapy	\$25 Copay	\$25 Copay	60% after Deductible	15% after Deductible	20% after Deductible	60% after Deductible
Inpatient & All Other Outpatient	15% after Deductible	20% after Deductible	60% after Deductible	15% after Deductible	20% after Deductible	60% after Deductible
ALL OTHER SERVICES	15% after Deductible	20% after Deductible	60% after Deductible	15% after Deductible	20% after Deductible	60% after Deductible
*PRESCRIPTION DRUGS	Retail	Mail Order		Tier 1 Deductible + Retail		+ Mail Order
Generic Brand	35%, \$10 min, \$100 max	35%, \$20 min, \$200 max		35%, \$10 min, \$100 max		35%, \$20 min, \$200 max
Formulary Name Brand	35%, \$40 min, \$120 max	35%, \$70 min, \$230 max		35%, \$40 min, \$120 max		35%, \$70 min, \$230 max
Non-Formulary Name Brand	50%, \$60 min, \$150 max	50%, \$120 min, \$250 max		50%, \$60 min, \$150 max		50%, \$120 min, \$250 max
Specialty Mail Order 30 Day Supply	-----	35%, \$90 min, \$170 max		-----		35%, \$90 min, \$170 max
	**NON-NETWORK BENEFITS:					
	No Coverage except Medical Emergency, Covered at Tier 2					

* Deductible and Out-of-Pocket Limit expenses cross accumulate for Tier I and Tier II only. For the PPO plan, medical copays and prescription drug co-insurance do not apply toward the Calendar Year Deductible, but do apply toward the Out-of-Pocket limit. For the High Deductible Health Plan (HDHP), prescription drug co-insurance applies toward the Deductible and Out-of-Pocket limit for Tier 1 and Tier 2 only. For the HDHP, prescription drug costs do not apply to Tier 3 Deductible and Out-of-Pocket limit.

** See reverse side for information regarding provider Tiers 1, 2, and 3.

This is a brief summary of the Methodist Health System Employee Health Care Plan options. It does not describe every situation and is not intended to replace the plan document. If there is any conflict between the summary and the plan document, the plan document will govern the resolution.

MONTHLY HEALTH COVERAGE COST - MJE

\$1,000 Deductible PPO Plan	Full-Time	Part-Time	Health Care Reform
Employee Only	\$ 106.00	\$ 229.00	\$ 596.00
Employee + Spouse	\$ 244.00	\$ 431.00	\$ 1,282.00
Employee + Child(ren)	\$ 208.00	\$ 377.00	\$ 1,138.00
Family	\$ 342.00	\$ 596.00	\$ 1,942.00
High Deductible Health Plan	Full-Time	Part-Time	Health Care Reform
Employee Only	\$ 50.00	\$ 156.00	\$ 582.00
Employee + Spouse	\$ 133.00	\$ 342.00	\$ 1,250.00
Employee + Child(ren)	\$ 122.00	\$ 289.00	\$ 1,110.00
Family	\$ 184.00	\$ 458.00	\$ 1,894.00

PPO HEALTH NETWORK

Tier 1 – Methodist Health System Facilities, Midwest Surgical Hospital and Methodist Provider Hospital Organization (PHO)

Tier 2 – Nebraska Medicine, Nebraska Health Partners, Children’s Hospital and Medical Center, Bryan Health, Montgomery County Memorial Hospital

Tier 3 – United Healthcare Choice Plus

www.umar.com | Click *Find a Provider* and type *Nebraska Methodist* into the search bar.

Telehealth Services Website: www.MethodistVirtualCare.com

FILING HEALTH CLAIMS

UMR processes all Methodist Health System health claims. To be reimbursed for health care when you use a Non-Network provider, you may need to complete a claim form and submit it along with your bill. If you have a question about your claim or if you would like to check if a specific service or procedure is covered, contact UMR directly.

UMR
1-800-826-9781