

# Medical Plan Options

## Your Role

Many retirees are not aware of what health care actually costs. You know that you pay a portion of the cost when you see your doctor, but do you really know how much the total visit costs? The idea behind consumerism is simple – if you're aware of the total cost, you'd spend benefit dollars more wisely. Since the County and your contributions ultimately pay for our health expenses, retirees can have a direct impact on the cost of health care and therefore the insurance premiums paid by the County.

Think about it like this: You don't agree to have your car repaired without knowing the total cost of the repair. As a smart health care consumer, you wouldn't pay doctor or prescription drug copays without some idea of the total cost of your care and the value you receive for that cost.

Now consider the health care purchasing process. The decision about what health care plan to buy is rarely made entirely by you – the consumer. Instead, you are in a health plan because that is what your employer offers. Instead, you know that you must go to a specific facility or doctor, either because it is required by the plan or because you can take advantage of an in-network provider discount. Yet often you don't know what value you are receiving for your care or the quality of the care, especially in a hospital environment. The plans introduced in 2003 do provide more incentive for you to be a good healthcare consumer.

As members of the St. Louis County Group Health Plan, you may choose from among various health plans. When making your decision about the plan that's right for you, you'll need to consider several factors, including; the amount that you will spend on deductible and coinsurance versus the amount you will be paying in premium under each option, the provider network, how often you and your family need medical care, and any upcoming medical expenses in the next year.

- ***GHP Basic***

This plan provides a basic level of coverage for medical services. You and your covered dependents may utilize both network and non-network providers (non-network benefits are subject to Reasonable & Customary Charges). All services, such as lab work, inpatient or outpatient hospital services, and prescription drug coverages will be covered at 80%, after a \$1,100 individual deductible is satisfied. The maximum out of pocket expense for an individual is \$4,000. Preventative Care office visits to a physician are \$25 for in-network and not subject to deductible. **Prescription copayments are \$10, \$25, and \$40 depending on whether generic preferred, name brand preferred, or non-preferred drugs are used and only apply after deductible has been satisfied. *Those enrolling in this plan do not have to designate a primary care physician.***

- ***GHP Primary POS & Primary PPO SELECT***

These plans provide a higher level of coverage for medical services. You and your dependents may utilize both network and non-network providers but more coverage is provided for network providers. Doctor office visit copays are \$15 for a primary care physician and \$15 for specialists. Other network provider services, such as lab work, inpatient or outpatient hospital services will be covered at 80%, after a \$250 individual deductible is satisfied. The maximum out of pocket in-network expense for an individual is \$1,250. Prescription drug copayments are \$10, \$25, and \$40 depending on whether generic preferred, name brand preferred, or non-preferred drugs are used. Prescription copays are not subject to the deductible and do not apply to out of pocket maximum. ***Those enrolling in this plan do not have to designate a primary care physician. The Primary POS Plan includes the broadest GHP network. The Primary PPO SELECT network does not include any hospitals or physicians affiliated with BJC Health Care.***

- ***GHP Comprehensive POS  
Comprehensive PPO SELECT***

These plans provide the highest level of benefits for medical services and offer the option to use network or non-network providers each time you and your dependents seek medical care. The non-network benefit resembles a traditional indemnity plan and requires that you pay a higher percentage of the cost (25% after a \$300 annual individual deductible). The network benefit includes copays for certain services and 100% coverage without copays for others. Doctor office visit copays are \$15 for a primary care physician and \$15 for specialists. Prescription drug copays are \$10, \$25 and \$40 depending on whether generic preferred, name brand preferred, or non-preferred drugs are used. ***Those enrolling in this plan do not have to designate a primary care physician. The Comprehensive POS Plan includes the broadest GHP network. The Comprehensive PPO SELECT network does not include any hospitals or physicians affiliated with BJC Health Care.***

***Annual Notice  
Women's Health & Cancer Act***

A federal law passed in 1998 requires all group and individual health plans that cover mastectomies to provide benefits for reconstructive surgery. Our plans generally cover the services now mandated by the new law. However, we are required to provide the notice of this coverage.

This coverage includes the following:

- Coverage for reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Coverage for prosthesis and physical complications of all stages of the mastectomy, including lymphedemas.

This coverage is determined in consultation with the patient and her physician and is subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

# Medical Plan Comparison Chart

THIS SUMMARIZES YOUR COST FOR CERTAIN SERVICES. REFER TO THE CERTIFICATE OF COVERAGE FOR A DETAILED DESCRIPTION OF COVERED SERVICES AND LIMITATIONS OR EXCLUSIONS.

Plan Feature	GHP Basic		GHP Primary POS GHP Primary PPO SELECT		GHP Comprehensive POS GHP Comprehensive PPO SELECT	
	In Network*	Out of** Network	In Network *	Out of** Network	In Network *	Out of ** Network
<b>Annual Deductible</b> • Individual • Family	\$1,100 \$3,300	\$1,100 \$3,300	\$250 \$750	\$500 \$1,500	None	\$300 \$600
<b>Coinsurance</b> (Will always apply after deductible)	20% of Covered Expenses After Deductible	40% of Covered Expenses After Deductible	20% of Covered Expenses After Deductible	40% of Covered Expenses After Deductible	0% of Covered Expenses	25% of Covered Expenses After Deductible
<b>Out-of-Pocket Max</b> (includes deductibles) • Individual • Family	\$4,000 \$9,000	\$4,000 \$9,000	\$1,250 \$3,750	\$2,500 \$7,500	None	\$2,000 \$5,000
<b>Preventative Care Office Visits</b> (Services include routine health assessments, well-child care, and immunizations)	\$25 copay (not subject to deductible)	40% of Covered Expenses	\$15	40% Of Covered Expenses	\$15	25% of Covered Expenses
<b>Pre-Existing Condition</b>	DOES NOT APPLY	DOES NOT APPLY	DOES NOT APPLY	DOES NOT APPLY	DOES NOT APPLY	DOES NOT APPLY
<b>Policy Maximum</b>	UNLIMITED	UNLIMITED	UNLIMITED	\$1,000,000	UNLIMITED	\$2,000,000
<b>Prescription Drugs</b> • <b>Retail</b> (30 day supply) Generic Preferred Brand Non-Preferred Brand	\$10 \$25 \$40 (COPAYS APPLY AFTER DEDUCTIBLE HAS BEEN SATISFIED)	Covered only at Network Pharmacies	\$10 \$25 \$40	Covered only at Network Pharmacies	\$10 \$25 \$40	Covered only at Network Pharmacies

GHP PRIMARY PPO SELECT NETWORK DOES NOT INCLUDE HOSPITALS OR PHYSICIANS AFFILIATED WITH WITH BJC HEALTH CARE  
GHP COMPREHENSIVE PPO SELECT NETWORK DOES NOT INCLUDE HOSPITALS OR PHYSICIANS AFFILIATED WITH BJC HEALTH CARE

# Medical Plan Comparison Chart *(continued)*

Plan Feature	GHP Basic		GHP Primary POS GHP Primary PPO SELECT		GHP Comprehensive POS GHP Comprehensive PPO SELECT	
	In Network*	Out of** Network	In Network *	Out of** Network	In Network *	Out of** Network
<b>Prescription Drugs (continued)</b> <ul style="list-style-type: none"> <li>• <b>Mail Order</b> (90 day supply) Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$80 (COPAYS APPLY AFTER DEDUCTIBLE HAS BEEN SATISFIED)</li> </ul>		Covered only at Network Pharmacies	\$20 \$50 \$80	Covered only at Network Pharmacies	\$20 \$50 \$80	Covered only at Network Pharmacies
<b>PCP/Specialist Outpatient Office Visits</b>	20% of Covered Expenses	40% of Covered Expenses	\$15	40% of Covered Expenses	\$15	25% of Covered Expenses
<b>Covered Immunizations Only</b> (children from birth to age 5 are covered at 100% of eligible expenses and are not subject to annual deductible)	\$25	40%	\$15	40% of Covered Expenses	\$15	25% of Covered Expenses
<b>Well Woman Care</b> (Including Pap Test)	\$25	40% of Covered Expenses	\$15	40% of Covered Expenses	\$15	25% of Covered Expenses
<b>Mammogram</b>	Covered 100%	40% of Covered Expenses	Covered 100%	40% of Covered Expenses	Covered 100%	25% of Covered Expenses

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# Medical Plan Comparison Chart *(continued)*

Plan Feature	GHP Basic		GHP Primary POS GHP Primary PPO SELECT		GHP Comprehensive POS GHP Comprehensive PPO SELECT	
	In Network *	Out of** Network	In Network *	Out of ** Network	In Network *	Out of** Network
<b>Independent X-Ray and Lab</b> (Routine Preventative Care X-Ray and Lab is covered at 100%)	20% of Covered Expenses (except for routine Preventative Care which is covered at 100%)	40% of Covered Expenses	20% of Covered Expenses (except for routine Preventative Care which is covered at 100%)	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
<b>Emergency</b> • <b>Room/Urgent Care</b> (waived if admitted)	20% of Covered Expenses	20% Covered Expenses	ER - \$75 UC - \$50	ER - \$75 UC - 40% Covered Expenses	ER - \$50 UC - \$50	ER - \$50 UC - \$50
• <b>Ambulance</b>	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
<b>Maternity</b> • Initial Visit to Confirm Pregnancy	20% of Covered Expenses	40% of Covered Expenses	\$15	40% of Covered Expenses	\$15	25% of Covered Expenses
• Prenatal/Postnatal Visits	20% of Covered Expenses	40% of Covered Expenses	Covered Under Initial Visit Copay	40% of Covered Expenses	Covered Under Initial Visit Copay	25% of Covered Expenses
• Hospital/Delivery	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses

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# Medical Plan Comparison Chart *(continued)*

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	In Network *	Out of** Network	In Network *	Out of ** Network	In Network *	Out of** Network
<b>Hospital Inpatient</b> • Doctor Visits	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
• Hospital Services	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
• Preadmission Testing	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
<b>Outpatient Surgical Facility</b>	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
<b>Surgery</b> • Surgeon's Fee	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
• Second Opinion Consultation	20% of Covered Expenses	40% of Covered Expenses	\$15 Copay	40% of Covered Expenses	\$15 Copay	25% of Covered Expenses
<b>Infertility</b> • Office Visit Diagnosis Only	20% of Covered Expenses	40% of Covered Expenses	\$15 Copay	40% of Covered Expenses	\$15 Copay	25% of Covered Expenses
• Surgery for Infertility	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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# Medical Plan Comparison Chart *(continued)*

Plan Feature	GHP Basic		GHP Primary POS GHP Primary PPO SELECT		GHP Comprehensive POS GHP Comprehensive PPO SELECT	
	In Network *	Out of ** Network	In Network *	Out of ** Network	In Network *	Out of ** Network
<b>Outpatient Rehabilitation</b> Includes Physical, Speech, Occupational • Up to 60 visits per year	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
<b>Chiropractic Therapy</b> <i>(Spinal Manipulation Only; covered up to 26 visits annually)</i>	20% of Covered Expenses	40% of Covered Expenses	\$15 Per Visit	40% of Covered Expenses	\$15 Per Visit	25% of Covered Expenses
<b>Special Services</b> • Skilled Nursing Facility (Up to 60 days per year)	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
• Home Health Care	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
• Hospice – Inpatient and Outpatient	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
<b>Durable Medical Equipment</b>	20% of Covered Expenses	40% of Covered Expenses	\$15	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
<b>External Prosthetic Appliances</b> <b>(Covers initial placement only)</b>	20% of Covered Expenses	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses

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	In Network *	Out of** Network	In Network *	Out of ** Network	In Network *	Out of** Network
<b>Mental Health *** And Alcohol &amp; Drug Abuse Rehabilitation</b>	20% of Covered Expense per inpatient admission	40% of Covered Expenses	20% of Covered Expenses	40% of Covered Expenses	Covered at 100%	25% of Covered Expenses
• Inpatient						
• Outpatient	20% of Covered Expenses	40% of Covered Expenses	\$15 Per Visit	40% of Covered Expenses	\$15 Per Visit	25% of Covered Expenses
• Group Therapy	20% of Covered Expenses	40% of Covered Expenses	\$15 Per Visit	40% of Covered Expenses	\$15 Per Visit	25% of Covered Expenses
<b>Vision Care Specialist</b>	Not covered for routine refractive exams	40% of Covered Expenses	\$15 Per Visit	40% of Covered Expenses	\$15 Per Visit	25% of Covered Expenses
<p>* All services must be provided by a GHP physician or Precertified by GHP to receive In-Network benefits.</p> <p>** Penalty for failure to Precertify out of network admissions and ancillary services.</p> <p>*** All Mental Health Services must be prior authorized in advance by calling GHP Behavioral Health Line at 1-877-227-3520.</p> <p>NOTE: All Out-of-Network benefits are subject to charges in excess of the Reasonable &amp; Customary Allowance.</p>						

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