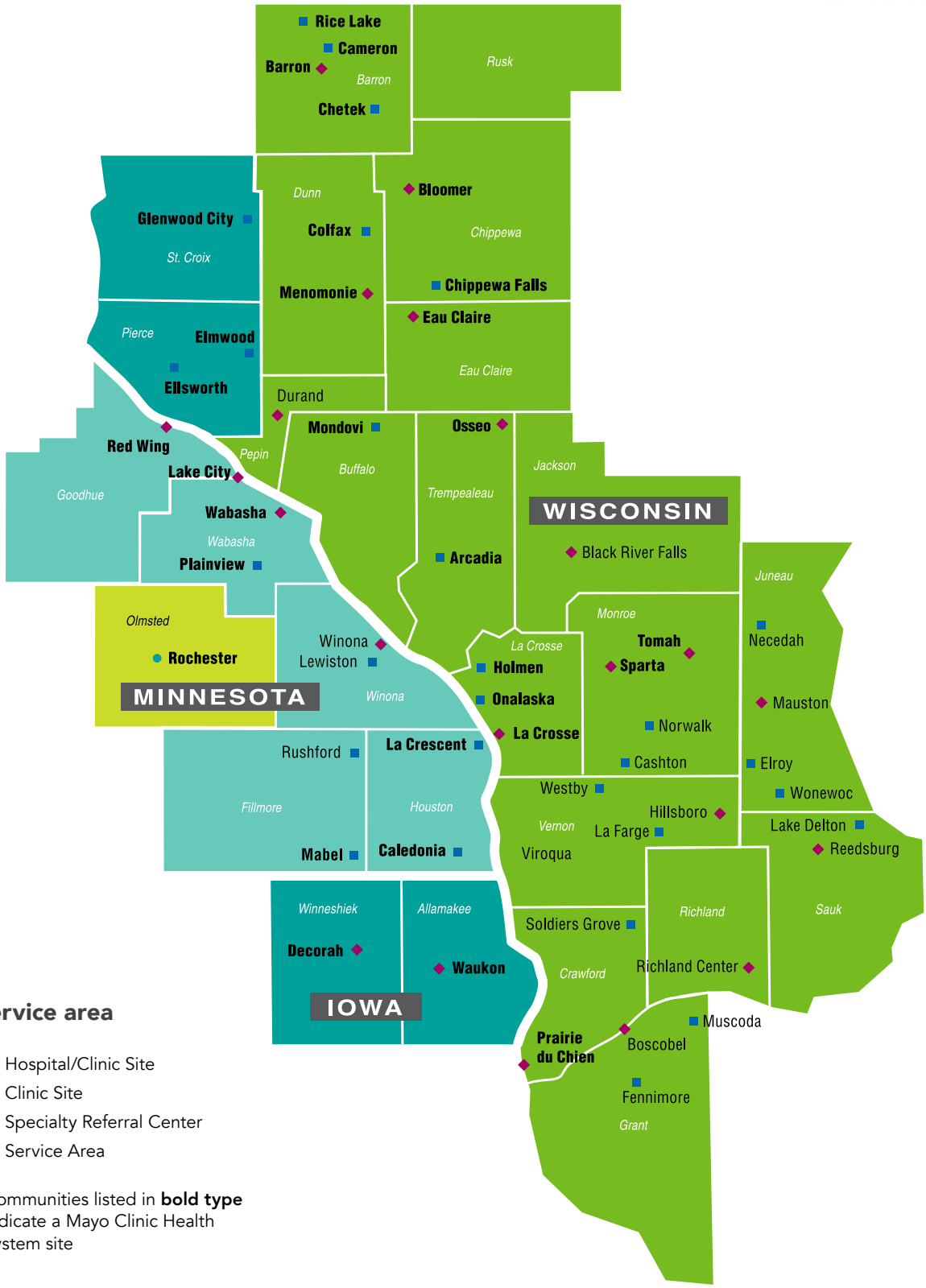
Small Group Plan Grids

2019

HEALTH TRADITION

A Higher Level of Health



Service area

- Hospital/Clinic Site
- Clinic Site
- Specialty Referral Center
- Service Area

Communities listed in **bold type** indicate a Mayo Clinic Health System site

2019 Small Group HMO Plans

HEALTH TRADITION

Covered Services (Calendar Year Benefits)	Platinum 1000 w/Copay	Gold 1000/80 w/Copay	Gold 1500/80	Gold 2000/90	Silver 1500/70 w/Copay	Silver 2000/70	Silver 2600/80 w/Copay
Annual Deductible Individual/Family†	$1,000/ $2,000	$1,000/ $2,000	$1,500/ $3,000	$2,000/ $4,000	$1,500/ $3,000	$2,000/ $4,000	$2,600/ $5,200
Annual Out-of-Pocket Maximum Individual/Family†	$2,000/ $4,000	$4,000/ $8,000	$4,000/ $8,000	$4,000/ $8,000	$7,000/ $14,000	$7,500/ $15,000	$7,500/ $15,000
Preventive Care*	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Deductible applies unless otherwise noted (Copays do not apply to deductible)							
Office Visits Primary/Specialist	$50/$75 Copay Deductible NA	$50/$75 Copay Deductible NA	20%	10%	$75/$150 Copay Deductible NA	30%	$75/$150 Copay Deductible NA
Chiropractic	$50 Copay Deductible NA	$50 Copay Deductible NA	20%	10%	$75 Copay Deductible NA	30%	$75 Copay Deductible NA
Urgent Care**	$50 Copay Deductible NA	$50 Copay Deductible NA	20%	10%	$75 Copay Deductible NA	30%	$75 Copay Deductible NA
Emergency Room Services** (Deductible, Copay, then coinsurance)	$150 Copay	$150 Copay then 20%	$100 Copay then 20%	$100 Copay then 10%	$200 Copay then 30%	$200 Copay then 30%	$300 Copay then 20%
Ambulance	0%	20%	20%	10%	30%	30%	20%
Hospitalization Inpatient/outpatient	0%	20%	20%	10%	30%	30%	20%
Outpatient Lab/Radiology	0%	20%	20%	10%	30%	30%	20%
Durable Medical Equipment	0%	20%	20%	10%	30%	30%	20%
Skilled Nursing Facilities	0%	20%	20%	10%	30%	30%	20%
Home Health Care	0%	20%	20%	10%	30%	30%	20%
Rehabilitation PT/OT/ST combined max of 60 visits/year	0%	20%	20%	10%	30%	30%	20%
Prenatal/Postnatal Care & Delivery	0%	20%	20%	10%	30%	30%	20%
Mental/Behavioral Health, Outpatient	$50 Copay Deductible NA	$50 Copay Deductible NA	20%	10%	$75 Copay Deductible NA	30%	$75 Copay Deductible NA
Mental/Behavioral Health, Inpatient	0%	20%	20%	10%	30%	30%	20%
Prescription Drugs **G=Generic** **B=Brand** **N=Non-formulary** **S=Specialty**	Deductible NA $15G $50 B 40% N 20% S	Deductible NA $15 G $50 B 40% N 20% S	Deductible NA $15 G $50 B 40% N 20% S	Deductible NA $25 G $60 B $80 N 20% S	Deductible NA $30 G $70 B $150 N 20% S	Deductible NA $30 G $70 B 40% N 20% S	Deductible NA $15 G $50 B 40% N 20% S

Endnotes on last page.

2019 Small Group HMO Plans

Plans in blue are qualified high-deductible plans compatible with Health Savings Accounts.

Covered Services (Calendar Year Benefits)	Bronze 6500/60	Bronze *** 7500/100	Gold HDHP 100	Silver HDHP 90	Silver HDHP 100	Bronze HDHP 50	Bronze HDHP 60	Bronze HDHP 80
Annual Deductible Individual/Family†	$6,500/ $13,000	$7,500/ $15,000	$3,000/ $6,000	$3,500/ $7,000	$5,000/ $10,000	$4,500/ $9,000	$5,000/ $10,000	$6,000/ $12,000
Annual Out-of-Pocket Maximum Individual/Family†	$7,500/ $15,000	$7,500/ $15,000	$3,000/ $6,000	$6,750/ $13,500	$5,000/ $10,000	$6,750/ $13,500	$6,750/ $13,500	$6,750/ $13,500
Preventive Care*	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
In addition to meeting the deductible, member pays								
Office Visits Primary/Specialist	40%	0%	0%	10%	0%	50%	40%	20%
Chiropractic	40%	0%	0%	10%	0%	50%	40%	20%
Urgent Care**	40%	0%	0%	10%	0%	50%	40%	20%
Emergency Room Services** (Deductible, Copay, then coinsurance)	40%	0%	0%	10%	0%	50%	40%	20%
Ambulance	40%	0%	0%	10%	0%	50%	40%	20%
Hospitalization Inpatient/outpatient	40%	0%	0%	10%	0%	50%	40%	20%
Outpatient Lab/Radiology	40%	0%	0%	10%	0%	50%	40%	20%
Durable Medical Equipment	40%	0%	0%	10%	0%	50%	40%	20%
Skilled Nursing Facilities	40%	0%	0%	10%	0%	50%	40%	20%
Home Health Care	40%	0%	0%	10%	0%	50%	40%	20%
Rehabilitation PT/OT/ST combined max of 60 visits/year	40%	0%	0%	10%	0%	50%	40%	20%
Prenatal/Postnatal Care & Delivery	40%	0%	0%	10%	0%	50%	40%	20%
Mental/Behavioral Health, Outpatient	40%	0%	0%	10%	0%	50%	40%	20%
Mental/Behavioral Health, Inpatient	40%	0%	0%	10%	0%	50%	40%	20%
Prescription Drugs **G=Generic** **B=Brand** **N=Non-formulary** **S=Specialty**	Deductible NA $30 G $75 B $150 N 20% S	After deductible 0%	After deductible 0%	After deductible 10% G 10% B 30% N 10% S	After deductible 0%	After deductible 50%	After deductible 40% G 40% B 60% N 20% S	After deductible 20% G 20% B 40% N 20% S

Endnotes on last page.

2019 Small Group Point of Service Plans

HEALTH TRADITION

Covered Services (Calendar Year Benefits)	Platinum 1000 w/Copay		Gold 1000/80 w/Copay		Gold 1500/80		Gold 2000/90		Silver 1500/70 w/Copay	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Annual Deductible Individual/Family†	$1,000/ $2,000	$2,000/ $4,000	$1,000/ $2,000	$2,000/ $4,000	$1,500/ $3,000	$3,000/ $6,000	$2,000/ $4,000	$4,000/ $8,000	$1,500/ $3,000	$3,000/ $6,000
Annual Out-of-Pocket Maximum Individual/Family†	$2,000/ $4,000	$4,000/ $8,000	$4,000/ $8,000	$8,000/ $16,000	$4,000/ $8,000	$8,000/ $16,000	$4,000/ $8,000	$8,000/ $16,000	$7,000/ $14,000	$14,000/ $28,000
Preventive Care*	100% Coverage	Not covered	100% Coverage	Not covered	100% Coverage	Not covered	100% Coverage	Not Covered	100% Coverage	Not covered
Deductible applies unless otherwise noted (Copays do not apply to deductible)										
Office Visits Primary/Specialist	$50/$75 Copay Deductible NA	20%	$50/$75 Copay Deductible NA	40%	20%	40%	10%	30%	$75/$150 Copay Deductible NA	40%
Chiropractic	$50 Copay Deductible NA	20%	$50 Copay Deductible NA	40%	20%	40%	10%	30%	$75 Copay Deductible NA	40%
Urgent Care**	$50 Copay Deductible NA	$50 Copay Deductible NA	$50 Copay Deductible NA	$50 Copay Deductible NA	20%	20%	10%	10%	$75 Copay Deductible NA	$75 Copay Deductible NA
Emergency Room Services** (Deductible, Copay, then coinsurance)	$150 Copay	$150 Copay	$150 Copay then 20%	$150 Copay then 20%	$100 Copay then 20%	$100 Copay then 20%	$100 Copay then 10%	$100 Copay then 10%	$200 Copay then 30%	$200 Copay then 30%
Ambulance	0%	0%	20%	20%	20%	20%	10%	10%	30%	30%
Hospitalization Inpatient/outpatient	0%	20%	20%	40%	20%	40%	10%	30%	30%	40%
Outpatient Lab/Radiology	0%	20%	20%	40%	20%	40%	10%	30%	30%	40%
Durable Medical Equipment	0%	20%	20%	40%	20%	40%	10%	30%	30%	40%
Skilled Nursing Facilities	0%	20%	20%	40%	20%	40%	10%	30%	30%	40%
Home Health Care	0%	20%	20%	40%	20%	40%	10%	30%	30%	40%
Rehabilitation PT/OT/ST combined max of 60 visits/year	0%	20%	20%	40%	20%	40%	10%	30%	30%	40%
Prenatal/Postnatal Care & Delivery	0%	20%	20%	40%	20%	40%	10%	30%	30%	40%
Mental/Behavioral Health, Outpatient	$50 Copay Deductible NA	20%	$50 Copay Deductible NA	40%	20%	40%	10%	30%	$75 Copay Deductible NA	40%
Mental/Behavioral Health, Inpatient	0%	20%	20%	40%	20%	40%	10%	30%	30%	40%
Prescription Drugs **G=Generic B=Brand N=Non-formulary S=Specialty**	Deductible NA $15 G $50 B 40% N 20% S	Not covered	Deductible NA $15 G $50 B 40% N 20% S	Not covered	Deductible NA $15 G $50 B 40% N 20% S	Not covered	Deductible NA $25 G $60 B $80 N 20% S	Not covered	Deductible NA $30 G $70 B $150 N 20% S	Not covered

Endnotes on last page.

2019 Small Group Point of Service Plans

HEALTH TRADITION

Covered Services (Calendar Year Benefits)	Silver 2000/70		Silver 2600/80 w/Copay		Bronze 6500/60		Bronze *** 7500/100	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Annual Deductible Individual/Family†	$2,000/ $4,000	$4,000/ $8,000	$2,600/ $5,200	$5,200/ $10,400	$6,500/ $13,000	$8,500/ $17,000	$7,500/ $15,000	$15,000/ $30,000
Annual Out-of-Pocket Maximum Individual/Family†	$7,500/ $15,000	$15,000/ $30,000	$7,500/ $15,000	$15,000/ $30,000	$7,500/ $15,000	$15,000/ $30,000	$7,500/ $15,000	$18,500/ $37,000
Preventive Care*	100% Coverage	Not Covered	100% Coverage	Not Covered	100% Coverage	Not Covered	100% Coverage	Not Covered
Deductible applies unless otherwise noted (Copays do not apply to deductible)								
Office Visits Primary/Specialist	30%	40%	$75/$150 Copay Deductible NA	40%	40%	40%	0%	20%
Chiropractic	30%	40%	$75 Copay Deductible NA	40%	40%	40%	0%	20%
Urgent Care**	30%	30%	$75 Copay Deductible NA	$75 Copay Deductible NA	40%	40%	0%	0%
Emergency Room Services** (Deductible, Copay, then coinsurance)	$200 Copay then 30%	$200 Copay then 30%	$300 Copay then 20%	$300 Copay then 20%	40%	40%	0%	0%
Ambulance	30%	30%	20%	20%	40%	40%	0%	0%
Hospitalization Inpatient/outpatient	30%	40%	20%	40%	40%	40%	0%	20%
Outpatient Lab/Radiology	30%	40%	20%	40%	40%	40%	0%	20%
Durable Medical Equipment	30%	40%	20%	40%	40%	40%	0%	20%
Skilled Nursing Facilities	30%	40%	20%	40%	40%	40%	0%	20%
Home Health Care	30%	40%	20%	40%	40%	40%	0%	20%
Rehabilitation PT/OT/ST combined max of 60 visits/year	30%	40%	20%	40%	40%	40%	0%	20%
Prenatal/Postnatal Care & Delivery	30%	40%	20%	40%	40%	40%	0%	20%
Mental/Behavioral Health, Outpatient	30%	40%	$75 Copay Deductible NA	40%	40%	40%	0%	20%
Mental/Behavioral Health, Inpatient	30%	40%	20%	40%	40%	40%	0%	20%
Prescription Drugs **G=Generic** **B=Brand** **N=Non-formulary** **S=Specialty**	Deductible NA $30 G $70 B 40% N 20% S	Not covered	Deductible NA $15 G $50 B 40% N 20% S	Not covered	Deductible NA $30 G $75 B $150 N 20% S	Not covered	After deductible 0%	Not covered

Endnotes on last page.

2019 Small Group Point of Service Plans

Plans in blue are qualified high-deductible plans compatible with Health Savings Accounts.

Covered Services (Calendar Year Benefits)	Gold HDHP 100		Silver HDHP 90		Silver HDHP 100		Bronze HDHP 50		Bronze HDHP 60		Bronze HDHP 80	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Annual Deductible Individual/Family†	$3,000/ $6,000	$6,000/ $12,000	$3,500/ $7,000	$5,500/ $11,000	$5,000/ $10,000	$10,000/ $20,000	$4,500/ $9,000	$9,000/ $18,000	$5,000/ $10,000	$10,000/ $20,000	$6,000/ $12,000	$12,000/ $24,000
Annual Out-of-Pocket Maximum Individual/Family†	$3,000/ $6,000	$8,000/ $16,000	$6,750/ $13,500	$13,500/ $27,000	$5,000/ $10,000	$11,600/ $23,200	$6,750/ $13,500	$13,500/ $27,000	$6,750/ $13,500	$13,500/ $27,000	$6,750/ $13,500	$13,500/ $27,000
Preventive Care*	100% Coverage	Not Covered	100% Coverage	Not Covered	100% Coverage	Not Covered	100% Coverage	Not Covered	100% Coverage	Not Covered	100% Coverage	Not Covered
In addition to meeting the deductible, member pays												
Office Visits Primary/Specialist	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Chiropractic	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Urgent Care**	0%	0%	10%	10%	0%	0%	50%	50%	40%	40%	20%	20%
Emergency Room Services** (Deductible, Copay, then coinsurance)	0%	0%	10%	10%	0%	0%	50%	50%	40%	40%	20%	20%
Ambulance	0%	0%	10%	10%	0%	0%	50%	50%	40%	40%	20%	20%
Hospitalization Inpatient/outpatient	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Outpatient Lab/Radiology	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Durable Medical Equipment	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Skilled Nursing Facilities	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Home Health Care	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Rehabilitation PT/OT/ST combined max of 60 visits/year	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Prenatal/Postnatal Care & Delivery	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Mental/Behavioral Health, Outpatient	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Mental/Behavioral Health, Inpatient	0%	20%	10%	30%	0%	20%	50%	50%	40%	40%	20%	40%
Prescription Drugs **G=Generic** **B=Brand** **N=Non-formulary** **S=Specialty**	After deductible 0%	Not covered	After deductible 10% G 10% B 30% N 10% S	Not covered	After deductible 0%	Not covered	After deductible 50%	Not covered	After deductible 40% G 40% B 60% N 20% S	Not covered	After deductible 20% G 20% B 40% N 20% S	Not covered

Endnotes on last page.

Endnotes:

† *Once a member of a family plan meets the individual deductible or maximum out-of-pocket, Health Tradition begins paying for covered services for that person, regardless of whether the family deductible or out-of-pocket maximum has been met.*

* *This Benefit Plan provides 100% coverage in-network for preventive health services as defined in Section 1001 of the Patient Protection and Affordable Care Act, with no cost sharing. Routine vision and hearing exam included.*

** *Out-of-network medical emergencies, urgent care and plan prior-approved referrals are covered as in-network benefit. See Certificate of Coverage for plan detail. (In service area, out of network urgent care not covered on HMO.)*

*** *Bronze 7500 is not considered a qualified HDHP plan because it exceeds the max out of pocket set by the IRS.*

Please see plan documents here:

https://www.healthtradition.com/home/coverage-summary-for-groups/

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HT MPD 3003 0519