

Transylvania University - Health Insurance Plan Options for 2017

TYPE OF SERVICE	Pioneer 2000 (formerly PCA Plan Option 1)		Pioneer 3000 (formerly PCA Plan Option 2)		Traditional Plan (formerly PPO Plan)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Health Reimbursement Account (HRA) Provided by Transylvania	\$1,000/individual \$2,000/employee +	\$1,000/individual \$2,000/employee +	\$1,000/individual \$2,000/employee +	\$1,000/individual \$2,000/employee +	\$0	\$0
DEDUCTIBLE individual/employee + or family	\$2,000/\$4,000	\$4,000 / \$8,000	\$3,000/\$6,000	\$6,000 / \$12,000	\$500 / \$1,000	\$1,000 / \$2,000
ANNUAL OUT OF POCKET MAXIMUM	\$3,000/individual \$6,000/employee +	\$6,000/individual \$12,000/employee +	\$4,000/individual \$8,000/employee +	\$8,000/individual \$16,000/employee +	\$2,500/individual \$5,000/employee +	\$5,000/individual \$10,000/employee +
Primary Care office visit	90% after ded.	70% after ded.	80% after ded.	60% after ded.	\$10 per visit	60% after ded.
Specialist office visit	90% after ded.	70% after ded.	80% after ded.	60% after ded.	\$10 per visit	60% after ded.
PREVENTIVE CARE						
Annual physical/health appraisal	100%	70% after ded.	100%	60% after ded.	Covered 100%	60% after ded.
Well-child checkups	100%	70% after ded.	100%	60% after ded.	Covered 100%	60% after ded.
Routine immunizations	100%	70% after ded.	100%	60% after ded.	Covered 100%	60% after ded.
Mammography screening	100%	70% after ded.	100%	60% after ded.	Covered 100%	60% after ded.
Colonoscopy	100%	70% after ded.	100%	60% after ded.	Covered 100%	60% after ded.
INPATIENT HOSPITAL						
Unlimited days	90% after ded.	70% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
OUTPATIENT HOSPITAL	90% after ded.	70% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
SURGERY						
Inpatient	90% after ded.	70% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Outpatient	90% after ded.	70% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Emergency Room (facility only)	90% after ded.	70% after ded.	80% after ded.	60% after ded.	100% after \$50 copay	60% after \$50 copay
MATERNITY/GYN						
Prenatal and Postpartum office visits	90% after ded.	70% after ded.	80% after ded.	60% after ded.	100% after \$10 copay for first visit	60% after ded.
Delivery (vaginal/ cesarean)	90% after ded.	70% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Routine GYN exams	100%	70% after ded.	100%	60% after ded.	Covered 100%	60% after ded.
PRESCRIPTION DRUG						
Generic drugs	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered
Preferred brand drugs	\$30	Not Covered	\$30	Not Covered	\$30	Not Covered
Non-preferred brand drugs	\$50	Not Covered	\$50	Not Covered	\$50	Not Covered
Specialty drugs	25% to \$2,500 max.	Not Covered	25% to \$2,500 max.	Not Covered	25% to \$2,500 max.	Not Covered
MENTAL HEALTH/ SUBSTANCE ABUSE						
Inpatient	90% after ded.	70% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Outpatient	90% after ded.	70% after ded.	80% after ded.	60% after ded.	\$10 per visit	60% after ded.
POLICY MAXIMUM	unlimited		unlimited		unlimited	
	Pioneer 2000		Pioneer 3000		Traditional Plan	
Monthly Plan Costs	Employee Cost	Employee Cost with HRA Completion	Employee Cost	Employee Cost with HRA Completion	Employee Cost	Employee Cost with HRA Completion
Single	\$143	\$93	\$108	\$58	\$228	\$178
Employee + Spouse	\$350	\$300	\$281	\$231	\$544	\$494
Employee + Child(ren)	\$302	\$252	\$241	\$191	\$470	\$420
Family	\$473	\$423	\$374	\$324	\$759	\$709