Clinton-Essex-Warren-Washington Schools Health Insurance Consortium

2017/2018 Plan Options Comparison

Benefit Description		**CEWW Platinum Plan 2 (amended benefit plan)**	
Plan Benefit and Cost Sharing Highlights		**In-Network**	**Out-of-Network**
Deductible	Individual	$250 Combined In-Network and Out-of-Network (Medical only) Rx plan not subject to deductible	
	Family	$750 Combined In-Network and Out-of-Network (Medical only) Rx plan not subject to deductible	
Coinsurance		**In-Network**	**Out-of-Network**
		20%	20%
Out-of-Pocket Maximum Medical Plan ***Member Medical Plan Coinsurnace (20%) Only***	Individual	$500 Combined In-Network and Out-of-Network (Medical only) Rx plan not subject to this out-of-pocket maximum	
	Family	$1,500 Combined In-Network and Out-of-Network (Medical only) Rx plan not subject to this out-of-pocket maximum	
Out-of-Pocket Maximum Prescription Drug Plan ***Member Prescripton Drug Copayments Only***	Individual	$500 (not included with Medical)	Not Applicable
	Family	$1,500 (not included with Medical)	Not Applicable
Annual Maximum		Unlimited	Unlimited
Lifetime Maximum		Unlimited	Unlimited
Preventive Health Care Services		**In-Network**	**Out-of-Network**
Well Child Visits		Covered In Full	100% of Allowed Amount
Adult Routine Physical Exams		Covered In Full	100% of Allowed Amount
Adult Immunizations		Covered In Full	100% of Allowed Amount
Mammography		Covered In Full	100% of Allowed Amount
Pap Smears		Covered In Full	100% of Allowed Amount
Routine Gynecological Exams		Covered In Full	100% of Allowed Amount
Prostrate Cancer Screenings		Covered In Full	100% of Allowed Amount
Colonoscopies		Preventive Screenings Covered in Full	Preventive Screenings 100% of Allowed Amount
Family Planning Services		Covered In Full	100% of Allowed Amount

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2017/2018 Plan Options Comparison

Benefit Description	**CEWW Platinum Plan 2 (amended benefit plan)**	
Physician Services	**In-Network**	**Out-of-Network**
Diagnostic Office Visits	20% After Deductible	20% After Deductible
Diagnostic X-Rays	Covered In Full	100% of Allowed Amount
Diagnostic Laboratory and Pathology	Covered In Full	100% of Allowed Amount
Allergy Tests	20% After Deductible	20% After Deductible
Allergy Injections	20% After Deductible	20% After Deductible
Chemotherapy	Covered In Full	100% of Allowed Amount
Radiation Therapy	Covered In Full	100% of Allowed Amount
Maternity Services	**In-Network**	**Out-of-Network**
Prenatal Services	Covered In Full	100% of Allowed Amount
Hospital Care for Mother (includes delivery)	Covered In Full	100% of Allowed Amount
Newborn Nursery Care	Covered In Full	100% of Allowed Amount
Prescription Drug Benefits	**In-Network**	**Out-of-Network**
Retail Pharmacy (see supply limits)	Tier 1 $5.00 (limited to a 30-day supply)	Not Covered
	Tier 2 $15.00 (limited to a 30-day supply)	Not Covered
	Tier 3 $30.00 (limited to a 30-day supply)	Not Covered
Mail-Order Pharmacy (limited to a 90-day supply)	Tier 1 $10.00	Not Covered
	Tier 2 $30.00	Not Covered
	Tier 3 $60.00	Not Covered
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Hospital Benefits (unlimited days)	Covered In Full	100% of Allowed Amount
Physician Visits in the Hospital	Covered In Full	100% of Allowed Amount
Inpatient Physical Rehabilitation (60-day limit)	Covered In Full	100% of Allowed Amount
Surgery	Covered In Full	100% of Allowed Amount
Anesthesia	Covered In Full	100% of Allowed Amount

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2017/2018 Plan Options Comparison

Benefit Description	**CEWW Platinum Plan 2 (amended benefit plan)**	
Emergency Care	**In-Network**	**Out-of-Network**
Emergency Room Care	Covered In Full	100% of Allowed Amount
Freestanding Urgent Care Center	Covered In Full	100% of Allowed Amount
Ambulance	Covered In Full	100% of Allowed Amount
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Diagnostic X-Rays	Covered In Full	100% of Allowed Amount
Diagnostic Laboratory and Pathology	Covered In Full	100% of Allowed Amount
Surgical Care Facility Fee	Covered In Full	100% of Allowed Amount
Chemotherapy	Covered In Full	100% of Allowed Amount
Radiation Therapy	Covered In Full	100% of Allowed Amount
Mental Health and Chemical Dependence	**In-Network**	**Out-of-Network**
Inpatient Mental Health Care (unlimited days)	Covered In Full	100% of Allowed Amount
Outpatient Mental Health Care (unlimited visits)	Covered In Full	100% of Allowed Amount
Inpatient Chemical Dependence	Covered In Full	100% of Allowed Amount
Outpatient Chemical Dependence	Covered In Full	100% of Allowed Amount
Other Services	**In-Network**	**Out-of-Network**
Diabetic Insulin and Supplies	20% After Deductible	20% After Deductible
Skilled Nursing Facility (limited to 200 days/year)	Covered In Full	100% of Allowed Amount
Home Care (limited to 40 visits per year)	Covered In Full	100% of Allowed Amount
Hospice Care	Covered In Full	100% of Allowed Amount
Outpatient Therapy (60 visits per condition/lifetime) (physical, speech, and occupational)	20% After Deductible	20% After Deductible
Durable Medical Equipment	Covered In Full	100% of Allowed Amount
External Prosthetics	Covered In Full	100% of Allowed Amount
Chiropractic Care	20% After Deductible	20% After Deductible
Acupuncture	Covered In Full	100% of Allowed Amount
Hearing Aids	Not Covered	Not Covered

Clinton-Essex-Warren-Washington Schools Health Insurance Consortium **2017/2018 Plan Options Comparison**			
Benefit Description		**CEWW Platinum Plan 2 (amended benefit plan)**	
Vision Benefits		**In-Network**	**Out-of-Network**
Adult Routine Vision Exam		Not Covered	Not Covered
Adult Diagnostic Vision Exam		Not Covered	Not Covered
Adult Eyewear		Not Covered	Not Covered
Pediatric Routine Vision Exam		Not Covered	Not Covered
Pediatric Eyewear		Not Covered	Not Covered
Dental Benefits		**In-Network**	**Out-of-Network**
Adult Dental Care		Not Covered	Not Covered
Pediatric Dental: Preventive and Routine		Not Covered	Not Covered
Pediatric Major Dental Care and Medical Ortho		Not Covered	Not Covered
Accidental Dental - Outpatient Surgery (accidental injury to sound, natural teeth and for care due to congenital disease or anomaly,)		Covered In Full	100% of Allowed Amount
Monthly Premium Rates		**Individual**	**Family**
2017/2018 Fiscal Year	***Eff. 7/1/2017***	***$604.86***	***$1,574.21***
	Eff. 1/1/2018	***$665.35***	***$1,731.63***