MDA HEALTH PLAN
BENEFITS AT A GLANCE
EFFECTIVE JANUARY 1, 2020

Classic Plus PPO $2,500 (4)		
	In-Network	**Out-of-Network**
Deductible		
Employee	$2,500	$5,000
Employee +1	$5,000	$10,000
Family	$7,500	$15,000
Coinsurance Maximum		
Employee	$3,000	$6,000
Employee + 1	$4,000	$8,000
Family	$5,000	$10,000
True Out-of-Pocket Maximum		
Employee	$7,500	$15,000
Employee + 1	$13,000	$26,000
Family	$15,000	$30,000
Lifetime Maximum	Unlimited	
PHYSICIAN SERVICES		
Physician Office Visit		
Primary Care	100% after $35 copay	60% after deductible
Specialist	100% after $55 copay	60% after deductible
Chiropractic Office Visit	100% after $35 copay	60% after deductible
Chiropractic Manipulation Maximum of 24 visits per calendar year	80% after deductible	60% after deductible
HOSPITAL SERVICES		
Hospital Services		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible
Pre-admission Testing	80% after deductible	60% after deductible
Emergency Room	80% after $100 copay and deductible; copay waived if admitted as an inpatient	
Urgent Care	$35 copay	60% after deductible
Nursery Charges	80% after deductible	60% after deductible
Pre-certification Penalty	You are required to obtain pre-certification before all hospital admissions (or within two working days following an emergency admission) and for skilled nursing, private duty nursing, and home health care services. Utilization Management can be reached at: 800-269-1260.	You are required to obtain pre-certification before all hospital admissions (or within two working days following an emergency admission) and for skilled nursing, private duty nursing, and home health care services. If pre-certification is not notified a $250 additional deductible will be applied. Utilization Management can be reached at: 800-269-1260.

Classic Plus PPO $2,500 (4)		
	In-Network	**Out-of-Network**
WELLNESS BENEFITS		
Well Baby Care / Immunizations (to age 5)	100%	Not covered
Preventive Care	100%	Not covered
Routine Physical Exam	100%	Not covered
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient Hospital	80% after deductible	60% after deductible
Outpatient Hospital	80% after deductible	60% after deductible
Outpatient Doctor's Office Visit	100% after $35 copay and deductible	60% after deductible
OTHER BENEFITS		
Physical/Occupational/Speech Therapy Max = combined 60 visits per calendar year	$55 copay	60% after deductible
Skilled Nursing Facility Max = 60 days per member per calendar year, prior certification required	80% after deductible	60% after deductible
Home Health Care Must be medically necessary	80% after deductible	60% after deductible
IN-NETWORK PRESCRIPTION DRUGS		
Generic		
Preferred	$10	
Non-Preferred	$20	
Brand		
Preferred	$60	
Non-Preferred	$120	
Specialty		
Preferred	20% to a maximum of $200	
Non-Preferred	50% to a maximum of $500	
	NOTE: a 90-day supply may be purchased, but the 90-day supply will be assessed 2 dispensing fees and the cost will be based on the cost of the medication. An in-network pharmacy must be used.	