



PARKLAND COLLEGE HEALTH PLAN HIGHLIGHTS

The following is a summary of the expenses covered under the two health plans. The chart lists what you would pay out-of-pocket for each benefit. Other limits and restrictions may apply. Please refer to your Parkland College Summary Plan Description (SPD)/Plan Document for detailed information regarding your plan. All full-time employees are eligible to elect benefits. Benefits are effective the first day of the month following your date of employment.

BENEFIT DESCRIPTION	HEALTH INCENTIVE PLAN	CHOICE PLAN
Lifetime Maximum Benefits		
Temporomandibular Joint (TMJ) Disorder	\$2,500	\$2,500
Plan Year Maximum Benefits		
Annual Plan Year Maximum	\$2,000,000	\$2,000,000
Skilled Nursing Care Facility	120 days	120 days
Outpatient Mental Health	25 visits	20 visits
Outpatient Substance Abuse	20 visits	20 visits
Inpatient Mental Health	25 days	14 days
Inpatient Substance Abuse	The lesser of 14 days or \$10,000	The lesser of 14 days or \$10,000
Outpatient Rehabilitative Therapy Services (Occupational, speech and physical therapies)	60 visits (treatment combined)	60 visits (treatment combined)
Spinal Manipulation/Chiropractic Services	\$750	Not covered
Hospice Care	60 days	60 days
Home Health Care	100 visits	100 visits
Plan Year Deductibles		
	YOU PAY	YOU PAY
Single	\$1,000	\$0
Family	\$2,000	\$0
	* indicates that no deductible applies	
Plan Year Out-of-Pocket Maximum		
Single	Deductibles, coinsurance and copayments	Coinsurance and copayments
Family	Deductibles, coinsurance and copayments	Coinsurance and copayments
Failure to preauthorize inpatient admissions and durable medical equipment, prosthetics, orthotics costing more than \$500.	*\$250	\$250
Inpatient Services		
	YOU PAY	YOU PAY
Hospital Care	0% after deductible	\$100 per admission
Number of Days Inpatient Care	Unlimited	Unlimited
Room and Board	0% after deductible	\$0
Procedures, Diagnostics and Therapeutics	0% after deductible	\$0
Skilled Care Facility	0% after deductible	\$0
Human Organ Transplant	0% after deductible	\$100
Mental Health Care	0% after deductible	\$100 per day
Substance Abuse Treatment	0% after deductible	\$100 per day
Hospice Care	0% after deductible	\$0
Outpatient Services		
Office Visit – Primary Care	0% after deductible	\$10 per visit
Office Visit – Specialty Care	0% after deductible	\$10 per visit
Procedures, Diagnostics and Therapeutics	0% after deductible	\$0
Hearing Screenings (Limited to one per plan year)	0% after deductible	\$10 per screening
Annual Physicals	*0%	\$10 per visit

BENEFIT DESCRIPTION	HEALTH INCENTIVE PLAN YOU PAY	CHOICE PLAN YOU PAY
Wellness Care	*0%	\$0
Well Baby Care (0-2)	*0%	\$0
Routine Eye Exams (Limited to one per plan year)	*Charges over \$60 per plan year	\$10 per visit
Medical Services		
Outpatient Surgery	0% after deductible	\$0
Maternity Care Inpatient Outpatient	*\$250 per pregnancy *0%	\$100 per admission \$0
Infertility Services	0% after deductible	\$10 per visit
Outpatient Mental Health Care	\$15 copayment, then 0% after deductible	\$15 per visit
Outpatient Substance Abuse Treatment	\$15 copayment, then 0% after deductible	\$15 per visit
Outpatient Rehabilitation (Occupational, speech and physical therapy)	0% after deductible	\$0
Diagnostic Testing	0% after deductible	\$0
Emergency Services		
Urgent Care	0% after deductible	\$10 per visit
Emergency Room Services	0% after deductible	\$50 per visit, copayment waived if admitted
Emergent Ambulance Transportation	0% after deductible	\$0
Other Services		
Durable Medical Equipment	20% after deductible	20%
Prosthetic/Orthotic Devices	20% after deductible	20%
Home Health Care/Home Infusion	0% after deductible	\$0
Temporomandibular Joint (TMJ) Disorder (Surgical procedures are not covered)	20% after deductible	\$10 per visit
Spinal Manipulation/Chiropractic Services (\$750 maximum annual benefit)	*50%	Not covered
Second and Third Surgical Opinions	*0%	\$0
Wisdom Teeth Removal (Impacted only)	0% after deductible	\$0
Retail Prescription Drugs (Limited to a 30-day supply)	*Tier 1 - \$7 *Tier 2 - \$15 *Tier 3 - \$30	Tier 1 - \$7 Tier 2 - \$15 Tier 3 - \$30
Mail Order Prescription Drugs (Limited to a 90-day supply)	*Tier 1 - \$7 *Tier 2 - \$15 *Tier 3 - \$30	Tier 1 - \$7 Tier 2 - \$15 Tier 3 - \$30
Specialty Prescription Drugs	*Tier 1 - \$7 *Tier 2 - \$15 *Tier 3 - \$30	Tier 1 - \$7 Tier 2 - \$15 Tier 3 - \$30
Smoking Cessation Medications (Receipts for over-the-counter products may be submitted for coverage)	*\$7	\$7
Contraceptive/Erectile Dysfunction Treatments Oral contraceptives, depo-provera, patches and impotency medications Contraceptive devices	*Tier 1 - \$7 *Tier 2 - \$15 *Tier 3 - \$30 20% after deductible	Tier 1 - \$7 Tier 2 - \$15 Tier 3 - \$30 20%
Vision Hardware Benefits (No deductible applies)		
*Single Vision Lenses, Frames and Contacts	Charges over \$120 per Plan Year	Not covered
*Bi-Focal Lenses, Frames and Contacts	Charges over \$138 per Plan Year	Not covered
*Tri-Focal Lenses, Frames and Contacts	Charges over \$150 per Plan Year	Not covered
*Lenticular Lenses and Frames	Charges over \$192 per Plan Year	Not covered
*Medically Necessary Contact Lenses	Charges over \$360 per Plan Year	Not covered

