

Plan Provision	Mission CDH Plan			Mission PPO Plan			Mission Basic Plan
	Mission Providers	Other In-Network	Out-of-Network*	Mission Providers	Other In-Network	Out-of-Network*	Network and Non-Network*
Annual Deductible							
Employee		\$3,000		\$250	\$500	\$750	\$1,200
Employee Plus One		\$4,000		\$500	\$1,000	\$1,500	\$2,400
Family		\$5,000		\$500	\$1,000	\$1,500	\$2,400
HRA Contribution		\$2,000 employee only \$3,000 employee plus one \$4,000 employee plus children/family		N/A	N/A	N/A	N/A
Coinsurance	90% (MH, TMH, BRHS)	70%	50%	90% (MH, TMH, BRHS)**	70%	50%	70%
Annual Out-of-Pocket Maximum							
Employee	\$2,000	\$2,000	None	\$2,000	\$4,000	None	\$4,000
Employee Plus One	\$4,000	\$4,000	N/A	\$4,000	\$8,000	None	\$8,000
Family	\$4,000	\$4,000	None	\$4,000	\$8,000	None	\$8,000
Office Visit							
Primary Care Physician (PCP)	70% after deductible	70% after deductible	50% after deductible	\$25 copay	\$25 copay	50% after deductible	70% after deductible
Specialist	70% after deductible	70% after deductible	50% after deductible	\$40 copay	\$40 copay	50% after deductible	70% after deductible
Wellness / Preventative	100% (no deductible)	100% (no deductible)	50% after deductible	100% after applicable co-pay amount	100% after applicable co-pay amount	50% after deductible	70% after deductible
Emergency Care	90% after deductible	70% after deductible	50% after deductible***	90% after deductible	70% after deductible	50% after deductible***	70% after deductible
Emergency Room Visits (not followed by admission)	90% after deductible	70% after deductible	50% after deductible***	\$100 copay waived if admitted	\$100 copay waived if admitted	\$100 copay waived if admitted	70% after deductible
Behavioral Health							
Inpatient Hospital Charges (Room and Board, Intensive Care, Ancillary Charges, Doctors Visits)	90% after deductible	70% after deductible	N/A	90% after deductible	70% after deductible	N/A	70% after deductible
Outpatient Charges (Doctors Visits limited to 20 visits per calendar year)	N/A	70% after deductible	N/A	N/A	70% after deductible	N/A	70% after deductible
Hospital Charges							
Inpatient (room and board (semi-private room); Intensive Care, Ancillary Charges)	90% after deductible	70% after deductible	50% after deductible	90% after deductible	70% after deductible	50% after deductible	70% after deductible
Outpatient (Preadmission testing, Ambulance)	90% after deductible	70% after deductible	50% after deductible	90% after deductible	70% after deductible	50% after deductible	70% after deductible
Routine Newborn Care	90% after deductible	70% after deductible	50% after deductible	90% after deductible	70% after deductible	50% after deductible	70% after deductible
Maternity Care	90% after deductible	70% after deductible	50% after deductible	90% after deductible	70% after deductible	50% after deductible	70% after deductible
Other Covered Services	90% after deductible	70% after deductible	50% after deductible	90% after deductible	70% after deductible	50% after deductible	70% after deductible
Vision Exam	N/A	70% (\$500 annual maximum applies to eyewear)	50% (\$500 annual maximum applies to eyewear)	70% \$50 maximum (eye exam only)	70% \$50 maximum (eye exam only)	50% \$50 maximum (eye exam only)	70%
Prescriptions (Up to a 30 day supply)****							
Deductible	\$0	\$75 employee or \$150 family	Not covered	\$0	\$75 employee or \$150 family	Not covered	70% after deductible
Generic	\$10 copay	\$25 copay	Not covered	\$10 copay	\$25 copay	Not covered	70% after deductible
Brand Preferred	\$20 copay	\$45 copay	Not covered	\$20 copay	\$45 copay	Not covered	70% after deductible
Brand Non-Preferred	\$45 copay	50% subject to a minimum copay of \$90 and a maximum copay of \$150	Not covered	\$45 copay	50% subject to a minimum copay of \$90 and a maximum copay of \$150	Not covered	70% after deductible
Mail Order Prescriptions (Up to a 90 day supply): Available at Mission Pharmacies Only (Medical Center Pharmacy, Mission Community Pharmacy, Hospital Drive Pharmacy (Spruce Pine), McDowell Hospital Pharmacy)							
Generic	(2 co-pays for 90 days of prescriptions) \$20	Not covered	Not covered	\$20 copay	Not covered	Not covered	70% after deductible
Brand Preferred	\$40	Not covered	Not covered	\$40 copay	Not covered	Not covered	70% after deductible
Brand Non-Preferred	\$90	Not covered	Not covered	\$90 copay	Not covered	Not covered	70% after deductible

* Subject to reasonable and customary limitations

** Mission Hospital, The McDowell Hospital, Blue Ridge Regional Hospital

*** True Emergencies covered at 70%

**** Pharmacy plans administered by AmericanhealthCare (AHC)