Effective Jan. 1, 2021

Medical Plan Side-by-Side

McCLATCHY LIVEWELL

Percentages shown indicate patient payment amount

	CLASSIC CARE PLAN		SAVINGS ADVANTAGE PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$400/person; $1,200/Family*	$1,000/person; $3,000/Family*	$2,000/EE Only; $4,000/EE+Sp/DP/Ch $6,000/EE + Family	$3,300/EE Only; $4,950/EE+Sp/DP/Ch $6,600/EE + Family
			(per person annual deductible does not apply)	
Out-of-Pocket Maximum - Person	$5,500/person	$10,000/person	$5,000/EE Only	$6,350/EE Only
Out-of-Pocket Maximum - Coverage Tier Includes deductible, copays and coinsurance	$11,000/EE+Sp/DP/Ch $11,000/EE+Family	$20,000/EE+Sp/DP/Ch Ch $20,000/EE+Family	$7,500/EE+Sp/DP/Ch $10,000/EE+Family	$9,525/EE+Sp/DP/Ch $12,700/EE+Family
PROFESSIONAL SERVICES				
Physician's Office Visit	$25 copay**	50% after deductible	20% after deductible	40% after deductible
Specialist Office Visit	$40 copay**			
Urgent Care Visit				
Inpatient Pre-Certification / Penalty - Applies to all inpatient services including hospitals, skilled nursing facilities, hospice and mental/nervous and chemical dependency stays	Provider responsible; no penalty	Member responsible; $250 penalty	Provider responsible; no penalty	Member responsible; $250 penalty
TYPE OF SERVICE				
Acupuncture - 12 visits per calendar year maximum	$40 copay**	50% after deductible	20% after deductible	40% after deductible
Allergy Testing - Office visit	$25 physican visit copay** or $40 specialist copay**			
Allergy Treatment	30% after deductible			
Ambulance - Must be medically necessary				
Diagnostic X-ray and Lab - Outpatient hospital or facility				
Durable Medical Equipment (DME)				
Emergency Room - No coverage for non-emergency use	30% after deductible; $125 copay per visit		20% after deductible	
Home Health Care - 120 visits per year max	30% after deductible	50% after deductible	20% after deductible	20% after deductible
Hospice Care - Inpatient and outpatient				
Hospital Inpatient - Includes room & board, physician expenses, prescription drugs and all other inpatient care				
Per Inpatient Admission Does not apply to Hospice, SNF or other facilities	$400 copay/stay 30% after deductible	$1,000 copay/stay 50% after deductible		
Per Inpatient Admission Copay Limit	$1,200/individual/year	$3,000/individual/year		
Hospital Outpatient/Surgery Includes outpatient services performed in a hospital, ambulatory surgical center or a doctor's office, including physician's charges	30% after deductible	50% after deductible		
Radiologists, Anesthesiologists & Pathologists				
Short Term Rehabilitation Outpatient physical, speech & occupational therapy	$40 copay**			
Skilled Nursing/Convalescent Facility 100 days per individual per year maximum	30% after deductible			
Spinal Disorders/Chiropractic Therapies 20 visits per individual per year maximum	$40 copay**			
MENTAL/NERVOUS DISORDERS/CHEMICAL DEPENDENCY				
Inpatient Mental/Nervous Disorders and Chemical Dependency	30% after deductible	50% after deductible	20% after deductible	20% after deductible
Per Inpatient Admission	$400/stay 30% after deductible	$1,000/stay 50% after deductible		
Per Inpatient Admission Copay Limit	$1,200/individual/year	$3,000/individual/year		
Outpatient Mental/Nervous Disorders and Chemical Dependency	$25 copay**	50% after deductible		
ROUTINE/PREVENTIVE CARE				
Preventive Care Subject to age and frequency limitations	No charge	No charge up to allowed amount**	20% after deductible	No charge up to allowed amount**
FAMILY PLANNING				
Contraceptive Devices, Implants & Injectables - Certain contraceptive devices may be covered at 100% with no copay or deductible	30% after deductible	50% after deductible	Preventative Care for SA Plan is at no charge	40% after deductible
Maternity				
PRESCRIPTION DRUGS				
Retail Pharmacy - 30 day supply				
Generic	$15	No Coverage	20% after deductible (deductible waived for certain preventive drugs)	No Coverage
Brand-Formulary	20% ($25 min/$90 max)			
Brand-Non Formulary	40% ($60 min/$150 max)			
Mail Order or Retail Pharmacy - 31-90 day supply				
Generic	$37.50			
Brand-Formulary	20% ($62.50 min/$225 max)			
Brand-Non Formulary	40% ($150 min/$375 max)			
ANNUAL EMPLOYEE RATES				
Employee Only	$2,058.24		$1,153.08	
Employee + Spouse/DP	$6,986.52		$4,303.80	
Employee + Child(ren)	$5,053.92		$3,113.40	
Employee + Family	$9,067.32		$5,585.88	

*Every individual on the plan must meet their own per person deductible unless the family deductible is met.
**Deductible does not apply