



Medical Plan Schedule of Benefits

The following pages are summaries of the Medical and Prescription Drug benefits. Please see the City of Savannah Summary Plan Description for details of covered benefits, limitations, and exclusions.

Medical	Plus Option		Basic Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible One Person Two Person Family	\$500 \$1,000 \$1,500	\$1,000 \$2,000 \$3,000	\$1,300 \$2,600 \$3,900	\$2,600 \$5,200 \$7,800
Maximum Out-of-Pocket One Person Two Person Family	\$2,200 \$4,400 \$6,600	No Maximum Amount No Maximum Amount No Maximum Amount	\$3,400 \$6,800 \$10,200	No Maximum Amount No Maximum Amount No Maximum Amount
Coinsurance - EE/ER	20% / 80%	50% / 50%	20% / 80%	50% / 50%
Physician Copay Primary Care Physician Specialist w/ PCP referral Specialist w/o PCP referral	\$15 \$25 \$50	50% after deductible	\$20 \$35 \$75	50% after deductible
Doctor on Demand Telemedicine	\$15	No benefits	\$20	No benefits
Ambulance Service	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Chiropractic Care	20% after deductible; limited to 25 visits per calendar year	50% after deductible; limited to 25 visits per calendar year	20% after deductible; limited to 25 visits per calendar year	50% after deductible; limited to 25 visits per calendar year
Hospital Services Inpatient Outpatient	20% after deductible 20% after deductible	50% after deductible & \$500 copay per admission 50% after deductible	20% after deductible 20% after deductible	50% after deductible & \$500 copay per admission 50% after deductible
Emergency Room	20% after deductible and \$200 co-pay	20% after deductible and \$200 co-pay	20% after deductible and \$200 co-pay	20% after deductible and \$200 co-pay
Urgent Care	\$15 co-pay	50% after deductible	\$20 co-pay	50% after deductible
Maternity Physician Hospital	\$200 copay and 20% after deductible	50% after deductible 50% after deductible	\$200 copay and 20% after deductible	50% after deductible 50% after deductible
Mental Health/Substance Abuse Inpatient Outpatient	20% after deductible \$15 copay	50% after deductible 50% after deductible	20% after deductible \$15 copay	50% after deductible 50% after deductible
Preventive Care Well Adult Care Well Child Care	100% 100%	No benefits No benefits	100% 100%	No benefits No benefits
Therapeutic Service (Occupational, Speech, and Physical Therapy)	20% after deductible; limited to 30 visits per calendar year	50% after deductible; limited to 30 visits per calendar year	20% after deductible; limited to 30 visits per calendar year	50% after deductible; limited to 30 visits per calendar year
Plus SAV4HEALTH Premium		Basic SAV4HEALTH Premium		
	Weekly	Bi-Weekly	Weekly	Bi-Weekly
Employee Only	\$20.46	Employee Only \$40.93	Employee Only \$12.63	Employee Only \$25.27
Employee +1	\$69.59	Employee +1 \$139.19	Employee +1 \$46.95	Employee +1 \$93.90
Family	\$127.38	Family \$254.76	Family \$87.55	Family \$175.10
Plus STANDARD Premium		Basic STANDARD Premium		
	Weekly	Bi-Weekly	Weekly	Bi-Weekly
Employee Only	\$39.69	Employee Only \$79.39	Employee Only \$31.86	Employee Only \$63.73
Employee +1	\$88.83	Employee +1 \$177.65	Employee +1 \$66.18	Employee +1 \$132.36
Family	\$146.61	Family \$293.22	Family \$106.78	Family \$213.56