## 2017 Benefit Comparison — State and Higher Education

PPO services in this table ARE NOT subject to a deductible and costs DO APPLY to the annual out-of-pocket maximum. CDHP services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. Costs DO APPLY to the annual out-of-pocket maximum.

<table>
<thead>
<tr>
<th>HEALTHCARE OPTION AND ACTUARIAL VALUE</th>
<th>PARTNERSHIP PPO 83.9%</th>
<th>STANDARD PPO 78.2%</th>
<th>HEALTHSAVINGS CDHP 83.9% (promise) 77% (no promise)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVERED SERVICES</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>Preventive Care — Office Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$25 copay</td>
<td>$45 copay</td>
<td>No charge</td>
</tr>
<tr>
<td>Specialty Office Visit</td>
<td>$45 copay</td>
<td>$70 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Behavioral Health and Substance Abuse</td>
<td>$25 copay</td>
<td>$45 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>X-Ray, Lab and Diagnostics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$25 copay</td>
<td>$45 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$45 copay</td>
<td>$70 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Behavioral Health and Substance Abuse</td>
<td>$25 copay</td>
<td>$45 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>X-Ray, Lab and Diagnostics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telehealth</td>
<td>$15 copay</td>
<td>N/A</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Allergy Injection</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Allergy Injection with Office Visit</td>
<td>$25 copay primary;</td>
<td>$45 copay primary;</td>
<td>$30 copay primary;</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>$45 copay specialist;</td>
<td>$70 copay specialist;</td>
<td>$50 copay specialist;</td>
</tr>
<tr>
<td>Visits 1-20</td>
<td>$25 copay visits</td>
<td>$45 copay visits</td>
<td>$30 copay visits</td>
</tr>
<tr>
<td>Visits 21-50: $45 copay</td>
<td>$25 copay visits</td>
<td>$45 copay visits</td>
<td>$30 copay visits</td>
</tr>
<tr>
<td>Speciality Medications (30-day supply from a specialty network pharmacy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-Day Supply</td>
<td>$7 copay generic;</td>
<td>copay plus amount</td>
<td>$14 copay generic;</td>
</tr>
<tr>
<td>90-Day Supply (90-day network pharmacy or mail order)</td>
<td>$40 copay preferred brand;</td>
<td>exceeding MAC;</td>
<td>$50 copay preferred brand;</td>
</tr>
<tr>
<td>90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order)</td>
<td>$80 copay preferred brand;</td>
<td>$100 copay preferred brand;</td>
<td></td>
</tr>
<tr>
<td>90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order)</td>
<td>$180 copay non-preferred;</td>
<td>$200 copay non-preferred;</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications (30-day supply from a specialty network pharmacy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONVENIENCE CLINIC AND URGENT CARE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convenience Clinic</td>
<td>$25 copay</td>
<td>$45 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$45 copay</td>
<td>$70 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>EMERGENCY ROOM</td>
<td>$150 copay (services subject to coinsurance may be extra)</td>
<td>$175 copay (services subject to coinsurance may be extra)</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

[1] ACTUARIAL VALUE

[2] Preventive Care — Office Visits

[3] Special Care and URGENT CARE

[4] CONVENIENCE CLINIC AND URGENT CARE

[5] EMERGENCY ROOM


Costs DO APPLY to the annual out-of-pocket maximum.

PPO services in this table ARE NOT subject to a deductible and costs DO APPLY to the annual out-of-pocket maximum.

CDHP services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. Costs DO APPLY to the annual out-of-pocket maximum.

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Preventive Care — Office Visits

- Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC)
- Adult annual physical exam
- Annual well-woman exam
- Immunizations as recommended by CDC
- Annual hearing and non-refractive vision screening
- Screenings including colonoscopy, mammogram and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force

Outpatient Services

Primary Care Office Visit
- Family practice, general practice, internal medicine, OB/GYN and pediatrics
- Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider
- Including surgery in office setting and initial maternity visit

Specialist Office Visit
- Including surgery in office setting

Behavioral Health and Substance Abuse

- Including reading, interpretation and results (not including advanced x-rays, scans and imaging)

X-Ray, Lab and Diagnostics

- Including reading, interpretation and results (not including advanced x-rays, scans and imaging)

Telehealth

100% covered

Allergy Injection

100% covered

Allergy Injection with Office Visit

100% covered up to MAC

Chiropractors

100% covered

Pharmacy

30-Day Supply

$7 copay generic; $40 copay preferred brand; $90 copay non-preferred

90-Day Supply (90-day network pharmacy or mail order)

$14 copay generic; $80 copay preferred brand; $180 copay non-preferred

90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order)

$7 copay generic; $40 copay preferred brand; $160 copay non-preferred

Specialty Medications (30-day supply from a specialty network pharmacy)

10% coinsurance; min $50; max $150

Convenience Clinic and Urgent Care

- $25 copay
- $45 copay

Emergency Room

- $150 copay (services subject to coinsurance may be extra)
- $175 copay (services subject to coinsurance may be extra)

EMERGENCY ROOM

- 20% coinsurance
# 2017 Benefit Comparison — State and Higher Education

All services in this table ARE subject to a deductible (with the exception of hospice under the PPO options). Eligible expenses DO APPLY to the annual out-of-pocket maximum.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>PARTNERSHIP PPO</th>
<th>STANDARD PPO</th>
<th>HEALTHSAVINGS COHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td><strong>MEDICAL AND PHARMACY COMBINED</strong></td>
<td><strong>DEDUCTIBLE</strong></td>
<td><strong>OUT-OF-POCKET MAXIMUM — MEDICAL AND PHARMACY COMBINED</strong></td>
</tr>
<tr>
<td><strong>OUT-OF-COUNTRY CHARGES</strong></td>
<td><strong>PARTNERSHIP PROMISE DISCOUNT/DEPOSIT</strong></td>
<td><strong>FOR INDIVIDUALS WHO AGREE TO COMPLETE THE PARTNERSHIP PROMISE</strong></td>
<td><strong>STATE CONTRIBUTION TO HSA:</strong></td>
</tr>
</tbody>
</table>

### Covered Services

**Hospital/Facility Services**
- Inpatient care; outpatient surgery
- Inpatient behavioral health and substance abuse

**Maternity**
- Global billing for labor and delivery and routine services beyond the initial office visit

**Home Care**
- Home health; home infusion therapy

**Rehabilitation and Therapy Services**
- Outpatient
- Skilled nursing facility

**Ambulance**
- Air and ground

**Hospice Care**
- Through an approved program

**Equipment and Supplies**
- Durable medical equipment and external prosthetics
- Other supplies (i.e., ostomy, bandages, dressings)

**Dental**
- Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)

**Advanced X-Ray, Scans and Imaging**
- Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies
- Reading and interpretation

**Out-of-Country Charges**
- Non-emergency and non-urgent care

### Deductible

**Employee Only**
- $500
- $1,000
- $1,000
- $2,000
- $1,500
- $3,000

**Employee + Child(ren)**
- $750
- $1,500
- $1,500
- $3,000
- $3,000
- $6,000

**Employee + Spouse**
- $1,000
- $2,000
- $2,000
- $4,000
- $3,000
- $6,000

**Employee + Spouse + Child(ren)**
- $1,250
- $2,500
- $2,500
- $5,000
- $3,000
- $6,000

### Out-of-Pocket Maximum — Medical and Pharmacy Combined

**Employee Only**
- $3,600
- $4,000
- $4,000
- $4,500
- $2,500
- $4,500

**Employee + Child(ren)**
- $5,400
- $6,000
- $6,000
- $6,750
- $5,000
- $9,000

**Employee + Spouse**
- $7,200
- $8,000
- $8,000
- $9,000
- $5,000
- $9,000

**Employee + Spouse + Child(ren)**
- $9,000
- $10,000
- $10,000
- $11,250
- $5,000
- $9,000

### Partnership Promise Discount/Deposit

- Premium discount: $500 for employee only and employee + child(ren) coverage; $100 for employee + spouse and employee + spouse + child(ren) coverage
- N/A

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted. For PPO Plans, no single family member will be subject to a deductible or out-of-pocket maximum greater than the “employee only” amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. For CDHP Plans, the out-of-pocket maximum amount can be met by one or more persons.

1. **Subject to maximum allowable charge (MAC).** The MAC is the most a plan will pay for a service from an in-network provider. For non-emergent care, non-contracted providers will pay the copay or coinsurance PLUS the difference between MAC and actual charge.

2. The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization (PA) is required.

3. Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diuretics, medications to control blood pressure and heart rate, statins, medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

4. **Prior authorization (PA) required.** When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)