2018 Benefit Comparison — State and Higher Education

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

HEALTHCARE OPTION AND	PREMIER PPO		STANDARD PPO		CDHP/HSA	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
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	No charge	$45 copay	No charge	$50 copay	No charge	40% coinsurance
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	$25 copay	$45 copay	$30 copay	$50 copay	20% coinsurance	40% coinsurance
Specialist Office Visit • Including surgery in office setting	$45 copay	$70 copay	$50 copay	$75 copay	20% coinsurance	40% coinsurance
Behavioral Health and Substance Use [2] • Including telebehavioral health	$25 copay	$45 copay	$30 copay	$50 copay	20% coinsurance	40% coinsurance
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	10% coinsurance		20% coinsurance		20% coinsurance	40% coinsurance
All Reading, Interpretation and Results	10% coinsurance		20% coinsurance		20% coinsurance	
Telehealth	$15 copay	N/A	$15 copay	N/A	20% coinsurance	N/A
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	20% coinsurance	40% coinsurance
Allergy Injection with Office Visit	$25 copay primary; $45 copay specialist	$45 copay primary; $70 copay specialist	$30 copay primary; $50 copay specialist	$50 copay primary; $75 copay specialist	20% coinsurance	40% coinsurance
Chiropractic • Limit of 50 visits per year	Visits 1-20: $25 copay Visits 21-50: $45 copay	Visits 1-20: $45 copay Visits 21-50: $70 copay	Visits 1-20: $30 copay Visits 21-50: $50 copay	Visits 1-20: $50 copay Visits 21-50: $75 copay	20% coinsurance	40% coinsurance
PHARMACY						
30-Day Supply	$7 copay generic; $40 copay preferred brand; $90 copay non-preferred	copay plus amount exceeding MAC	$14 copay generic; $50 copay preferred brand; $100 copay non-preferred	copay plus amount exceeding MAC	20% coinsurance	40% coinsurance plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 copay generic; $80 copay preferred brand; $180 copay non-preferred	N/A - no network	$28 copay generic; $100 copay preferred brand; $200 copay non-preferred	N/A - no network	20% coinsurance	N/A - no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 copay generic; $40 copay preferred brand; $160 copay non-preferred	N/A - no network	$14 copay generic; $50 copay preferred brand; $180 copay non-preferred	N/A - no network	10% coinsurance without first having to meet deductible	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10% coinsurance; min $50; max $150	N/A - no network	10% coinsurance; min $50; max $150	N/A - no network	20% coinsurance	N/A - no network
CONVENIENCE CLINIC AND URGENT CARE						
Convenience Clinic	$25 copay	$45 copay	$30 copay	$50 copay	20% coinsurance	40% coinsurance
Urgent Care Facility	$45 copay	$70 copay	$50 copay	$75 copay	20% coinsurance	40% coinsurance
EMERGENCY ROOM						
Emergency Room Visit	$150 copay (services subject to coinsurance may be extra)		$175 copay (services subject to coinsurance may be extra)		20% coinsurance	

2018 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.

	PREMIER PPO		STANDARD PPO		CDHP/HSA	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
Hospital/Facility Services • Inpatient care; outpatient surgery [4] • Inpatient behavioral health and substance abuse [2] [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Home Care [4] • Home health; home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Rehabilitation and Therapy Services • Inpatient [4]; outpatient • Skilled nursing facility [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance		20% coinsurance	
Hospice Care [4] • Through an approved program	100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (after the deductible has been met)	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
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)	10% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons
	10% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance
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
CDHP STATE HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION						
For individuals who enroll in the CDHP	N/A		N/A		State contribution to HSA: $250 for employee only; $500 for employee+child(ren), employee+spouse and employee+spouse+child(ren) coverage	

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 (MAC) 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 Plan, the deductible and out-of-pocket maximum amount can be met by one or more persons. For CDHP Plan, coinsurance is after deductible is met unless otherwise noted.

[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 from an out-of-network provider who charges more than the MAC, you 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/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient" prior authorization (PA) is required for certain outpatient services, such as psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits beyond 45-50 minutes in duration with our without medication management, and Applied Behavior Analysis.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; 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.)