2019 Health Plan 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.

HEALTHCARE OPTION	PREMIER PPO		STANDARD PPO		CDHP/HSA	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OFFICE VISITS						
• Well-baby, well-child visits as recommended • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended • Annual hearing and non-refractive vision screening • Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No charge	$45 copay	No charge	$50 copay	No charge	40% coinsurance
OUTPATIENT SERVICES — SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA						
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 • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	$45 copay	$70 copay	$50 copay	$75 copay	20% coinsurance	40% coinsurance
Behavioral Health and Substance Use [2] • Including virtual visits	$25 copay	$45 copay	$30 copay	$50 copay	20% coinsurance	40% coinsurance
Telehealth (approved carrier programs only)	$15 copay	N/A	$15 copay	N/A	20% coinsurance	N/A
Allergy Injection Without an Office Visit	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	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
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 Visit	$150 copay		$175 copay		20% 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

2019 Health Plan Comparison — State and Higher Education

PPO services in this table ARE subject to a deductible unless noted with a [5]. CDHP/HSA services in this table ARE subject to a deductible with the exception of in-network preventive care.

	PREMIER PPO		STANDARD PPO		CDHP/HSA	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE – OUTPATIENT FACILITIES						
• Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended	No charge	40% coinsurance	No charge	40% coinsurance	No charge	40% coinsurance
OTHER SERVICES						
Hospital/Facility Services [4] • Inpatient care; outpatient surgery • Inpatient behavioral health and substance abuse [2]	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 and skilled nursing facility [4]; outpatient • Outpatient IN-NETWORK physical, occupational and speech therapy [5]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging) [5]	10% coinsurance		20% coinsurance		20% coinsurance	40% coinsurance
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
All Reading, Interpretation and Results [5]	10% coinsurance		20% coinsurance		20% coinsurance	
Ambulance (air and ground)	10% coinsurance		20% coinsurance		20% coinsurance	
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
Also Covered	Certain limited Dental benefits, Hospice Care and Out-of-Country Charges are also covered subject to applicable deductible and coinsurance. See separate sections in the Member Handbook for details.					
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 – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE, COUNT TOWARD THE OUT-OF-POCKET MAXIMUM						
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)	

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 but must be met in full before it is considered satisfied. See the "Out of Pocket Maximums" section in the Member Handbook for more details. 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 covered service. 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 or 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.

[5] For PPO Plans, the deductible DOES NOT apply. For CDHP, the dedutible DOES apply as required.