# 2018 Benefit Comparison— Local Education and Local Government

PPO services in this table ARE NOT subject to a deductible. Local CDHP/HSA 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.

| HEALTHCARE OPTION | PREMIER PPO | | STANDARD PPO | | LIMITED PPO | | LOCAL CDHP/HSA | |
|---|---|---|---|---|---|---|---|---|
| **COVERED SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK [1]** | **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)<br>• Adult annual physical exam<br>• Annual well-woman exam<br>• Immunizations as recommended by CDC<br>• Annual hearing and non-refractive vision screening<br>• 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 | $50 copay | No charge | 50% coinsurance |
| **OUTPATIENT SERVICES** | | | | | | | | |
| **Primary Care Office Visit**<br>• Family practice, general practice, internal medicine, OB/GYN and pediatrics<br>• Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider<br>• Including surgery in office setting and initial maternity visit | $25 copay | $45 copay | $30 copay | $50 copay | $35 copay | $55 copay | 30% coinsurance | 50% coinsurance |
| **Specialist Office Visit**<br>• Including surgery in office setting | $45 copay | $70 copay | $50 copay | $75 copay | $55 copay | $80 copay | 30% coinsurance | 50% coinsurance |
| **Behavioral Health and Substance Use** [2]<br>• Including telebehavioral health | $25 copay | $45 copay | $30 copay | $50 copay | $35 copay | $55 copay | 30% coinsurance | 50% coinsurance |
| **X-Ray, Lab and Diagnostics** (not including advanced x-rays, scans and imaging) | 10% coinsurance | | 20% coinsurance | | 30% coinsurance | | 30% coinsurance | 50% coinsurance |
| **All Reading, Interpretation and Results** | 10% coinsurance | | 20% coinsurance | | 30% coinsurance | | 30% coinsurance | |
| **Telehealth** | $15 copay | N/A | $15 copay | N/A | $15 copay | N/A | 30% coinsurance | N/A |
| **Allergy Injection** | 100% covered | 100% covered up to MAC | 100% covered | 100% covered up to MAC | 100% covered | 100% covered up to MAC | 30% coinsurance | 50% coinsurance |
| **Allergy Injection with Office Visit** | $25 copay primary;<br>$45 copay specialist | $45 copay primary;<br>$70 copay specialist | $30 copay primary;<br>$50 copay specialist | $50 copay primary;<br>$75 copay specialist | $35 copay primary;<br>$55 copay specialist | $55 copay primary;<br>$80 copay specialist | 30% coinsurance | 50% coinsurance |
| **Chiropractic**<br>• Limit of 50 visits per year | Visits 1-20: $25 copay<br>Visits 21-50: $45 copay | Visits 1-20: $45 copay<br>Visits 21-50: $70 copay | Visits 1-20: $30 copay<br>Visits 21-50: $50 copay | Visits 1-20: $50 copay<br>Visits 21-50: $75 copay | Visits 1-20: $35 copay<br>Visits 21-50: $55 copay | Visits 1-20: $55 copay<br>Visits 21-50: $80 copay | 30% coinsurance | 50% coinsurance |
| **PHARMACY** | | | | | | | | |
| **30-Day Supply** | $7 copay generic;<br>$40 copay preferred brand;<br>$90 copay non-preferred | copay plus amount exceeding MAC | $14 copay generic;<br>$50 copay preferred brand;<br>$100 copay non-preferred | copay plus amount exceeding MAC | $14 copay generic;<br>$60 copay preferred brand;<br>$110 copay non-preferred | copay plus amount exceeding MAC | 30% coinsurance | 50% coinsurance plus amount exceeding MAC |
| **90-Day Supply** (90-day network pharmacy or mail order) | $14 copay generic;<br>$80 copay preferred brand;<br>$180 copay non-preferred | N/A - no network | $28 copay generic;<br>$100 copay preferred brand;<br>$200 copay non-preferred | N/A - no network | $28 copay generic;<br>$120 copay preferred brand;<br>$220 copay non-preferred | N/A - no network | 30% coinsurance | N/A - no network |
| **90-Day Supply** (certain maintenance medications from 90-day network pharmacy or mail order) [3] | $7 copay generic;<br>$40 copay preferred brand;<br>$160 copay non-preferred | N/A - no network | $14 copay generic;<br>$50 copay preferred brand;<br>$180 copay non-preferred | N/A - no network | $14 copay generic;<br>$60 copay preferred brand;<br>$200 copay non-preferred | N/A - no network | 20% coinsurance without first having to meet deductible | N/A - no network |
| **Specialty Medications** (30-day supply from a specialty network pharmacy) | 10% coinsurance;<br>min $50; max $150 | N/A - no network | 10% coinsurance;<br>min $50; max $150 | N/A - no network | 10% coinsurance;<br>min $50; max $150 | N/A - no network | 30% coinsurance | N/A - no network |
| **CONVENIENCE CLINIC AND URGENT CARE** | | | | | | | | |
| **Convenience Clinic** | $25 copay | $45 copay | $30 copay | $50 copay | $35 copay | $55 copay | 30% coinsurance | 50% coinsurance |
| **Urgent Care Facility** | $45 copay | $70 copay | $50 copay | $75 copay | $55 copay | $80 copay | 30% coinsurance | 50% coinsurance |
| **EMERGENCY ROOM** | | | | | | | | |
| **Emergency Room Visit** | $150 copay<br>(services subject to coinsurance may be extra) | | $175 copay<br>(services subject to coinsurance may be extra) | | $200 copay<br>(services subject to coinsurance may be extra) | | 30% coinsurance | |

# 2018 Benefit Comparison— Local Education and Local Government

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 | | LIMITED PPO | | LOCAL CDHP/HSA | |
|---|---|---|---|---|---|---|---|---|
| **COVERED SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK [1]** | **IN-NETWORK** | **OUT-OF-NETWORK [1]** | **IN-NETWORK** | **OUT-OF-NETWORK [1]** | **IN-NETWORK** | **OUT-OF-NETWORK [1]** |
| **Hospital/Facility Services**<br>• Inpatient care; outpatient surgery [4]<br>• Inpatient behavioral health and substance abuse [2] [4] | 10% coinsurance | 40% coinsurance | 20% coinsurance | 40% coinsurance | 30% coinsurance | 50% coinsurance | 30% coinsurance | 50% coinsurance |
| **Maternity**<br>• Global billing for labor and delivery and routine services beyond the initial office visit | 10% coinsurance | 40% coinsurance | 20% coinsurance | 40% coinsurance | 30% coinsurance | 50% coinsurance | 30% coinsurance | 50% coinsurance |
| **Home Care** [4]<br>• Home health; home infusion therapy | 10% coinsurance | 40% coinsurance | 20% coinsurance | 40% coinsurance | 30% coinsurance | 50% coinsurance | 30% coinsurance | 50% coinsurance |
| **Rehabilitation and Therapy Services**<br>• Inpatient [4]; outpatient<br>• Skilled nursing facility [4] | 10% coinsurance | 40% coinsurance | 20% coinsurance | 40% coinsurance | 30% coinsurance | 50% coinsurance | 30% coinsurance | 50% coinsurance |
| **Ambulance**<br>• Air and ground | 10% coinsurance | | 20% coinsurance | | 30% coinsurance | | 30% coinsurance | |
| **Hospice Care** [4]<br>• 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 (even if deductible has not been met) | | 100% covered up to MAC (after the deductible has been met) | |
| **Equipment and Supplies** [4]<br>• Durable medical equipment and external prosthetics<br>• Other supplies (i.e., ostomy, bandages, dressings) | 10% coinsurance | 40% coinsurance | 20% coinsurance | 40% coinsurance | 30% coinsurance | 50% coinsurance | 30% coinsurance | 50% coinsurance |
| **Dental**<br>• 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 | 30% coinsurance for oral surgeons | 50% coinsurance for oral surgeons | 30% coinsurance for oral surgeons | 50% coinsurance for oral surgeons |
| | 10% coinsurance non-contracted providers (i.e., dentists, orthodontists) | | 20% coinsurance non-contracted providers (i.e., dentists, orthodontists) | | 30% coinsurance non-contracted providers (i.e., dentists, orthodontists) | | 30% coinsurance non-contracted providers (i.e., dentists, orthodontists) | |
| **Advanced X-Ray, Scans and Imaging**<br>• Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4] | 10% coinsurance | 40% coinsurance | 20% coinsurance | 40% coinsurance | 30% coinsurance | 50% coinsurance | 30% coinsurance | 50% coinsurance |
| **Out-of-Country Charges**<br>• Non-emergency and non-urgent care | N/A - no network | 40% coinsurance | N/A - no network | 40% coinsurance | N/A - no network | 50% coinsurance | N/A - no network | 50% coinsurance |
| **DEDUCTIBLE** | | | | | | | | |
| Employee Only | $500 | $1,000 | $1,000 | $2,000 | $1,600 | $3,000 | $2,000 | $4,000 |
| Employee + Child(ren) | $750 | $1,500 | $1,500 | $3,000 | $2,200 | $4,000 | $4,000 | $8,000 |
| Employee + Spouse | $1,000 | $2,000 | $2,000 | $4,000 | $2,500 | $4,600 | $4,000 | $8,000 |
| Employee + Spouse + Child(ren) | $1,250 | $2,500 | $2,500 | $5,000 | $3,200 | $6,000 | $4,000 | $8,000 |
| separate pharmacy deductible applies | N/A | | N/A | | $100 per member | | N/A | |
| **OUT-OF-POCKET MAXIMUM** – MEDICAL AND PHARMACY COMBINED | | | | | | | | |
| Employee Only | $3,600 | $4,000 | $4,000 | $4,500 | $6,600 | $10,000 | $5,000 | $8,000 |
| Employee + Child(ren) | $5,400 | $6,000 | $6,000 | $6,750 | $13,200 | $20,000 | $10,000 | $16,000 |
| Employee + Spouse | $7,200 | $8,000 | $8,000 | $9,000 | $13,200 | $20,000 | $10,000 | $16,000 |
| Employee + Spouse + Child(ren) | $9,000 | $10,000 | $10,000 | $11,250 | $13,200 | $20,000 | $10,000 | $16,000 |

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 Local CDHP Plan**, the deductible and out-of-pocket maximum amount can be met by one or more persons, depending on premium level, but no one family member may contribute more than $7,350 to the in-network family out-of-pocket maximum total. **For Local 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 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. (For DME, PA only applies to more expensive items.)