

Medical & Prescription Drug At-A-Glance

	HDHP WITH HSA	STANDARD PPO WITH FSA	
	IN-/OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE: Amount you pay before the plan begins to pay. For the PPO Plan, office visit copays do not count toward the medical deductible, and there are separate medical and prescription drug deductibles.			
Single ¹	\$1,500	\$400	\$600 per individual
Family ²	\$3,000	\$800	
ANNUAL MEDICAL COST-SHARE MAXIMUM: After you meet this amount, <u>plus</u> pay the deductible, the plan pays 100% of covered services for the rest of the plan year. (Works like percentage cost-share.) The cost-share maximum includes what you pay in both dollar and percentage copays and for covered services. Medical and/or prescription drug deductibles do not count toward the cost-share maximum. For the PPO Plan, there are separate medical and prescription drug cost-share maximums.			
Single ¹	\$3,100	\$3,600	\$5,200 per individual
Family ²	\$6,200	\$7,200	

For the HDHP, if one family member's covered services meets the \$3,100 individual cost-share maximum, the plan pays 100 percent of covered services for that person for the rest of the plan year. When any combination of family members' covered services meets the \$6,200 family cost-share maximum, the plan pays 100 percent of covered services for all family members for the rest of the plan year.

ANNUAL PRESCRIPTION DRUG DEDUCTIBLE			
Single ¹	N/A	\$125	
Family ²		\$250	
ANNUAL PRESCRIPTION DRUG COST-SHARE MAXIMUM: After you meet this amount, <u>plus</u> pay your annual prescription drug deductible (if applicable), the plan pays 100% of covered prescriptions for the rest of the plan year.			
Single ¹	N/A	\$3,225	
Family ²		\$6,450	
COMBINED MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM: The most you'll pay in a plan year (annual medical and prescription drug deductibles plus annual medical and prescription drug cost-share maximums).			
Single ¹	\$4,600	\$7,350	\$9,150
Family ²	\$9,200 per family; \$6,100 per individual	\$14,700	\$5,800 per individual for medical; \$6,700 for family for prescription drugs
MEDICAL BENEFITS			
Preventive care	You pay \$0	You pay \$0	You pay full cost
Office visit	30% of maximum allowance after deductible	\$25 copay, not subject to or applied to deductible	35% of maximum allowance after deductible
Lab work, imaging (MRI, CT Scan, PET), etc.	30% of maximum allowance after deductible	20% of maximum allowance after deductible	35% of maximum allowance after deductible

¹ Single reflects Employee Only coverage level.

² Family includes the following coverage levels: Employee + Spouse or Other Eligible Adult, Employee + Child, Employee + Children, Employee + Family (spouse or other eligible adult + children).

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BEHAVIORAL HEALTH				
Inpatient services	30% of maximum allowance after deductible		20% of maximum allowance after deductible and \$100 per-day copay up to \$300 maximum copay per year	35% of maximum allowance after deductible and \$100 per-day copay up to \$300 maximum copay per year
Outpatient psychotherapy	30% of maximum allowance after deductible		\$25 copay per visit, not subject to or applied to deductible	35% of maximum allowance after deductible
HOSPITAL BENEFITS				
Emergency services	30% of maximum allowance after deductible		20% of maximum allowance after deductible	
Inpatient	30% of maximum allowance after deductible		20% of maximum allowance after deductible and \$100 per-day copay up to \$300 maximum copay per year	35% of maximum allowance after deductible and \$100 per-day copay up to \$300 maximum copay per year
Outpatient	30% of maximum allowance after deductible		20% of maximum allowance after deductible	35% of maximum allowance after deductible
MATERNITY SERVICES				
Physician	30% of maximum allowance after deductible		\$250 copay (not subject to deductible or cost-share) then plan pays 100%	35% of maximum allowance after deductible and \$100 per-day copay up to \$300 maximum copay per year
Hospital	30% of maximum allowance after deductible		20% of maximum allowance after deductible and \$100 per-day copay up to \$300 maximum copay per year	35% of maximum allowance after deductible and \$100 per-day copay up to \$300 maximum copay per year
PRESCRIPTION DRUG BENEFIT				
	HDHP WITH HSA		STANDARD PPO WITH FSA	
	Retail Pharmacy	Mail Order	Retail Pharmacy	Mail Order
Generic	100% of drug cost until you meet the deductible; then 30% of maximum allowance		25% (\$12 min., \$25 max.)	\$36
Preferred brand name³			25% (\$25 min., \$75 max.)	\$75
Non-preferred brand name³			25% (\$40 min., \$100 max.)	\$120

Note that under both plans, bariatric surgery requires pre-authorization and has a separate \$1,500 deductible that does not count toward the medical or prescription drug deductibles. Services must be provided by a Centers of Excellence provider and/or facility. Under the PPO, you pay 20% of the maximum allowance after the deductible. Under the HDHP, you pay 30% of the maximum allowance after the deductible. Under both plans, the cost-share amounts do not count toward the cost-share maximum.

³ If you buy a brand name drug instead of an available generic drug, you pay the applicable brand copay plus 100 percent of the cost difference between the brand name and generic.