

2013 STATE HEALTH BENEFIT PLAN BENEFITS COMPARISON

	Wellness HRA	Standard HRA	Wellness HMO	Standard HMO	Wellness HDHP	Standard HDHP
	In-Network/Out-of-Network	In-Network/Out-of-Network	In-Network Only	In-Network Only	In-Network/Out-of-Network	In-Network/Out-of-Network
Deductible						
You	\$1,600	\$1,600	\$1,300	\$1,300	\$1,800/\$3,600	\$2,000/\$4,000
You and Spouse	\$2,800	\$2,800	\$1,950	\$1,950	\$3,600/\$7,200	\$4,000/\$8,000
You and Child(ren)	\$2,800	\$2,800	\$1,950	\$1,950	\$3,600/\$7,200	\$4,000/\$8,000
You and Family	\$4,000	\$4,000	\$2,600	\$2,600	\$3,600/\$7,200	\$4,000/\$8,000
HRA Dollar Credits						
You	\$500	\$150	N/A	N/A	N/A	N/A
You and Spouse	\$1,000	\$300	N/A	N/A	N/A	N/A
You and Child(ren)	\$1,000	\$300	N/A	N/A	N/A	N/A
You and Family	\$1,500	\$500	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum						
You	\$4,000	\$4,500	\$4,000+co-pays	\$4,500+copays	\$4,000/\$8,000	\$4,500/\$9,000
You and Spouse	\$6,500	\$7,000	\$6,500+co-pays	\$7,000+copays	\$8,000/\$16,000	\$9,000/\$18,000
You and Child(ren)	\$6,500	\$7,000	\$6,500+co-pays	\$7,000+copays	\$8,000/\$16,000	\$9,000/\$18,000
You and Family	\$9,000	\$9,500	\$9,000+co-pays	\$9,500+copays	\$8,000/\$16,000	\$9,000/\$18,000
Medical Services						
Preventive Care, Well Child Exams & Immunizations	No cost to you ----- (in-network only)	No cost to you ----- (in-network only)	No cost to you ----- (in-network only)	No cost to you ----- (in-network only)	No cost to you ----- (in-network only)	No cost to you ----- (in-network only)
Office Visits (including Mental Health & Substance Abuse)	15% after deductible, 40% after deductible	15% after deductible, 40% after deductible	\$35 primary care physician (PCP) \$45 specialist (SPC)	\$55 primary care physician (PCP) \$65 specialist (SPC)	10% after deductible/ 40% after deductible	20% after deductible/ 40% after deductible
Inpatient/Outpatient Hospital Services (including Mental Health & Substance Abuse)	15% after deductible, 40% after deductible	15% after deductible, 40% after deductible	20% after deductible (Out-of-Network for Emergency only)	20% after deductible (Out-of-Network for Emergency only)	10% after deductible/ 40% after deductible	20% after deductible/ 40% after deductible
Outpatient Testing, Lab, etc. , diagnostic tests	15% after deductible, 40% after deductible	15% after deductible, 40% after deductible	20% coinsurance; after deductible	20% coinsurance; after deductible	10% after deductible/ 40% after deductible	20% after deductible/ 40% after deductible
Maternity Services	15% after deductible, 40% after deductible	15% after deductible, 40% after deductible	\$35 PCP copay then covered in full	\$55 PCP copay then covered in full	10% after deductible/ 40% after deductible	20% after deductible/ 40% after deductible
Emergency Care	15% after deductible	15% after deductible	\$150 copay; waived if admitted	\$150 copay; waived if admitted	10% after deductible	20% after deductible
Urgent Care	15% after deductible, 40% after deductible	15% after deductible, 40% after deductible	\$35 copay	\$55 copay	10% after deductible/ 40% after deductible	20% after deductible/ 40% after deductible
Eye Exam (every 24 months)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prescription Drugs (30 days) Minimum = min Maximum = max Ie (\$15/\$60)	Tier 1: 15% (\$20/\$50) Tier 2: 25% (\$50/\$80) Tier 3: 25% (\$80/\$125)	Tier 1: 15% (\$20/\$50) Tier 2: 25% (\$50/\$80) Tier 3: 25% (\$80/\$125)	Tier 1: \$20 copay Tier 2: \$50 copay Tier 3: \$90 copay	Tier 1: \$20 copay Tier 2: \$50 copay Tier 3: \$90 copay	Tier 1: 20% \$10/(\$100) Tier 2: 20% (\$10/\$100) Tier 3: 20% (\$10/\$100) No out-of-network coverage	Tier 1: 20% (\$10/\$100) Tier 2: 20% (\$10/\$100) Tier 3: 20% (\$10/\$100) No out-of-network coverage