Comparing the 2013 Partnership and Standard PPOs — Services that Require Copays

Services in this table ARE NOT subject to a deductible and costs DO NOT APPLY to the annual out-of-pocket coinsurance maximum.

	PARTNERSHIP PPO		STANDARD PPO	
COVERED SERVICES	**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, prostate, 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
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
Specialist Office Visit * • Including surgery in office setting	$45 copay	$70 copay	$50 copay	$75 copay
Mental Health and Substance Abuse * [2]	$25 copay	$45 copay	$30 copay	$50 copay
X-Ray, Lab and Diagnostics • Including reading, interpretation and results (not including advanced x-rays, scans and imaging)	100% covered after office copay, if applicable	100% covered up to MAC after office copay, if applicable	100% covered after office copay, if applicable	100% covered up to MAC after office copay, if applicable
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
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
Chiropractors	Visits 1-20: $25 copay Visits 21 and up: $45 copay	Visits 1-20: $45 copay Visits 21 and up: $70 copay	Visits 1-20: $30 copay Visits 21 and up: $50 copay	Visits 1-20: $50 copay Visits 21 and up: $75 copay
Pharmacy				
30-Day Supply	$5 copay generic; $35 copay preferred brand; $85 copay non-preferred brand	Copay plus amount exceeding MAC	$10 copay generic; $45 copay preferred brand; $95 copay non-preferred brand	Copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$10 copay generic; $65 copay preferred brand; $165 copay non-preferred brand	Copay plus amount exceeding MAC	$20 copay generic; $85 copay preferred brand; $185 copay non-preferred brand	Copay plus amount exceeding MAC
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [4]	$5 copay generic; $30 copay preferred brand; $160 copay non-preferred	Copay plus amount exceeding MAC	$10 copay generic; $40 copay preferred brand; $180 copay non-preferred	Copay plus amount exceeding MAC
Urgent Care				
Convenience Clinic or Urgent Care Facility	$30 copay		$35 copay	
Emergency Room				
Emergency Room Visit (waived if admitted) **	$125 copay		$145 copay	

*** Out-of-Pocket Copay Maximum — per individual** (applies to **in-network** office visits for primary care, specialist care and mental health and substance abuse treatment); **$900 Partnership PPO; $1,100 Standard PPO**

** Services subject to coinsurance may be extra

Services that Require Coinsurance — Deductibles and Out-of-Pocket Coinsurance Maximums

Services in this table ARE subject to a deductible and eligible expenses CAN BE APPLIED to the annual out-of-pocket coinsurance maximum.

	PARTNERSHIP PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
Hospital/Facility Services • Inpatient care [3] • Outpatient surgery [3] • Inpatient mental health and substance abuse [2] [3]	10% 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
Home Care [3] • Home health • Home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Rehabilitation and Therapy Services • Inpatient [3]; outpatient • Skilled nursing facility [3]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance	
Hospice Care [3] • 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)	
Equipment and Supplies [3] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% 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	40% coinsurance
	10% 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 [3]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
• Reading and interpretation	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance
Deductible				
Employee Only	$450	$800	$800	$1,500
Employee + Child(ren)	$700	$1,250	$1,250	$2,350
Employee + Spouse	$900	$1,600	$1,600	$3,000
Employee + Spouse + Child(ren)	$1,150	$2,050	$2,050	$3,850
Out-of-Pocket Coinsurance Maximum				
Employee Only	$1,550	$2,900	$1,900	$3,600
Employee + Child(ren)	$2,450	$4,600	$3,100	$5,900
Employee + Spouse	$3,100	$5,800	$3,800	$7,200
Employee + Spouse + Child(ren)	$4,000	$7,500	$5,000	$9,500

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. 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 will not be counted.

[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 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, and intensive outpatient therapy. Prior authorization (PA) is required for psychological testing and electroconvulsive therapy.

[3] 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.)

[4] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies; statins (see page 2).