

DEHIC

HA PPO / EPO Select 20 Benefit Comparison  
Effective 7/1/17



Benefit	Healthy Advantage PPO		EPO Select 20	
	In-Network	Out-of Network	In Network	
Deductible	\$0	\$500/\$1,250	\$0	
Coinsurance	10%	30%	0%	
Coinsurance Stop Loss	\$2,500/\$6,250 (\$250/\$625 out-of-pocket)	\$3,000/\$7,500 (\$900/\$2,250 out-of-pocket)	N/A	
Out-of-Pocket Maximum	\$5,080 individual/ \$12,700 family	\$1,400 Individual / \$3,500 Family	\$5,080 individual/ \$12,700 family	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Dependent Children (covered to the end of the month)	Dependents to age 26	Dependents to age 26	Dependents to age 26	
<b>Preventive Care</b>				
Adult Preventive Care	\$0	Deductible and Coinsurance	\$0	
Annual Physical Exam	\$0	Covered in-network only	\$0	
Well-Child Care (Up to age 19; including necessary immunizations)	\$0	Deductible and Coinsurance	\$0	
Well-Woman Care	\$0	Deductible and Coinsurance	\$0	
<b>Home/Office/Outpatient Care</b>				
Home/Office Visits	\$30 copay *	Deductible and Coinsurance	\$20 copay	
Emergency Room/Facility (initial visit per occurrence)	\$50 copay (Waived if admitted within 24 hours)	\$50 copay (Waived if admitted within 24 hours)	\$50 copay (Waived if admitted within 24 hours)	
Maternity Care	\$30 copay first visit, Coinsurance all other visits/services	Deductible and Coinsurance	\$0	
Allergy Testing & Treatment	Office visit \$30 copay Testing: Coinsurance Treatment: \$0	Deductible and Coinsurance	\$20 copay (waived for treatment)	
Home Healthcare	Coinsurance (Up to 365 visits per calendar year)	Coinsurance (no deductible)	\$0 (Up to 200 visits per calendar year)	
Home Infusion Therapy	Coinsurance	Covered in-network only	\$0	
Hospice Care (Up to 210 days per lifetime)	Coinsurance	Covered in-network only	\$0	
Surgery, Presurgical Testing, Anesthesia	\$30 copay applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance. (Unlimited visits per year for PT)	Deductible and Coinsurance	\$0	
Chemotherapy, Radiation Therapy		Deductible and Coinsurance	\$0	
Laboratory Tests, X-rays		Deductible and Coinsurance	\$0	
MRI/MRA, CAT Scan, PET & Nuclear Cardiology		Deductible and Coinsurance	\$0	
Chiropractic Care		Deductible and Coinsurance	\$20 copay	
Physical Therapy		Covered in-network only	\$20 copay (30 visits outpatient, 90 days inpatient max per year)	
Other Short-Term Rehabilitative Therapies - Speech/Language, Occupational (Up to 30 visits per calendar year combined in home, office or outpatient facility)		Covered in-network only	\$20 copay	
Vision Therapy		Covered in-network only	\$20 copay	
Cardiac Rehabilitation (Unlimited visits per calendar year)		Deductible and Coinsurance	\$20 copay	
Second Surgical Opinion		Deductible and Coinsurance	\$20 copay	
Kidney Dialysis		Deductible and Coinsurance	\$0	
<b>Inpatient Care</b>				
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)		Coinsurance	Deductible and Coinsurance	\$0
Surgery, Surgical Assistant, Anesthesia	Coinsurance	Deductible and Coinsurance	\$0	
Physical Therapy, Physical Medicine, or Rehabilitation	Coinsurance (Unlimited Inpatient visits per year for PT)	Deductible and Coinsurance	\$0 (maximum 90 days inpatient per year)	
Skilled Nursing Facility	Coinsurance (Up to 365 visits per calendar year)	Covered in-network only	\$0 (60 days per calendar year)	

	Healthy Advantage PPO		EPO Select 20
Benefit	In-Network	Out-of Network	In Network
<b>Mental Health</b>			
Outpatient Visits in Office	\$30 copay applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance	Deductible and Coinsurance	\$20 copay
Outpatient Visits in Facility	Coinsurance	Deductible and Coinsurance	\$0
Inpatient Care (As many days as is medically necessary; semiprivate room and board)	Coinsurance	Deductible and Coinsurance	\$0
<b>Alcohol/Substance Abuse</b>			
Outpatient Visits in Office	\$30 copay applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance	Deductible and Coinsurance	\$20 copay
Outpatient Visits in Facility	Coinsurance	Deductible and Coinsurance	\$0
Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	Coinsurance	Deductible and Coinsurance	\$0
Inpatient Rehabilitation	Coinsurance	Deductible and Coinsurance	\$0
<b>Other</b>			
Medical Supplies	Coinsurance	Difference between the allowed amount and the total charge	\$0
Durable Medical Equipment	Coinsurance	Covered in-network only	\$0
Prosthetics & Orthotics	Coinsurance	Covered in-network only	\$0
Ambulance (Land/Air ambulance)	Coinsurance	In-network benefits apply	\$0
<b>Prescription Drugs</b>			
Retail Program – One copay required for up to a 30-day supply	\$50 Deductible per person per calendar year Deductible does not apply to Tier 1 Generic drugs Tier 1/Tier 2/Tier3 \$10/\$20/\$40 Includes Contraceptives (Retail & Mail-Order)	Covered in-network only	\$0 Deductible  Tier 1/Tier 2/Tier3 \$10/\$20/\$40 Includes Contraceptives (Retail & Mail-Order)
Mail-Order Program – Only two copays required for a 90-day supply	\$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above	Covered in-network only	\$0 Deductible  The Mail-Order Program has the same copayments as the Retail Program listed above
Routine Vision Care	<b>Vision benefits - once every 12 months frequency</b>  \$5 copay for 1 exam  \$10 eyeglass lense copay  \$115 allowance then 20% off remaining balance for frames  \$75 allowance then 15 % off remaining balance for conventional contacts	<b>Vision benefits - once every 12 months frequency</b>  \$30 allowance for out-of-network exam \$64 allowance for pair of frames \$25-\$35 allowance for lenses	<b>Vision benefits - once every 12 months frequency</b>  \$5 copay for 1 exam  \$10 eyeglass lense copay  \$115 allowance then 20% off remaining balance for frames  \$75 allowance then 15 % off remaining balance for conventional contacts

\*office visits are covered at \$30 copay. All other services are subject to co-insurance. The \$30 office visit copay is for examinations/evaluations/consultations. Other services done during the visit would have the co-insurance applied (ie MRI)

**NOTE: Please refer to your SPD (Summary Plan Description) for detailed information regarding your coverage as well as services that require pre-certification. This is a benefit comparison only and is subject to terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased.**