2018 Health Plan Benefit Summary

	PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	**Non-PPO**	**PPO**	**Non-PPO**	**PPO**	**Non-PPO**
Calendar Year Deductible						
Individual	$500 (not transferable between plans)		$500 (not transferable between plans)		$300	$600
Family	$1000 (not transferable between plans)		$1000 (not transferable between plans)		$900	$1,800
Maximum Calendar Year Co-pay or Co-Insurance (excluding pharmacy)						
Individual	$3000 (co-insurance)	N/A	$2000 (co-insurance)	N/A	$3,000	N/A
Family	$6000 (co-insurance)	N/A	$4000 (co-insurance)	N/A	$6,000	N/A
Hospital *(including Mental Health and Substance Abuse)*						
Deductible (per admission)	N/A		N/A		N/A	
Inpatient	20%	40%	10%	40%	10%	
Oupatient Facility/Surgery Services	20%	40%	10%	40%	10%	
Emergency Services						
Emergency Room Deductible	$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)		N/A	
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	20% (applies to other services such as physician, x-ray, lab, etc)		10% (applies to other services such as physician, x-ray, lab, etc)		10%	
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	20%	40%	10%	40%	50%	
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(for non-emergency services provided by hospital emergency room)	

	PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Emergency Services (Cont.)						
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	20% (payment for physician charges only; emergency room facility charge is not covered)	40%	10% (payment for physician charges only; emergency room facility charge is not covered)	40%	50% (for non-emergency services provided by hospital emergency room)	
Physician Services *(including Mental Health and Stubstance Abuse)*						
Office Visits (co-pay for each service provided)	$20	40%	$20	40%	$20	10%
Inpatient Visits	20%	40%	10%	40%	10%	10%
Outpatient Visits	$20	40%	$20	40%	10%	10%
Urgent Care Visits	$20	40%	$20	40%	10%	10%
Preventive Services	No Charge	40%	No Charge	40%	No Charge	
Surgery/Anesthesia	20%	40%	10%	40%	10%	10%
Diagnostic X-Ray/Lab	20%	40%	10%	40%	10%	10%
Prescription Drugs						
Deductible	N/A		N/A		N/A	
Retail Pharmacy (not to exceed 30-day supply)	Generic: $5 Preferred: $20 Non-Preferred: $50		Generic: $5 Preferred: $20 Non-Preferred: $50 (not to exceed 34 day supply)		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
Retail Pharmacy Maintenance Medications filled after 2nd fill *(i.e. a medication taken longer than 60 days) (not to exceed 30-day supply)*	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100 (not to exceed 34 day supply)		N/A	
Mail Order Pharmacy Program (not to exceed 90- day supply for maintenance drugs)	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $20 Brand Formulary: $40 Non-Formulary: $75	N/A

	PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs (Cont.)						
Mail order maximum co-payment per person per calendar year	$1,000		$1,000		N/A	
Durable Medical Equipment						
	20% (pre-certification required for equipment)	40%	10% (pre-certification required for equipment $1000 or more)	40%	20%	20%
Infertility Testing/Treatment						
	Not Covered		Not Covered		50%	50%
Occupational / Physical / Speech Therapy						
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		$20 ; Speech therapy: 10%	10%
Outpatient (office and home visits)	20% (Pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	10% (Pre-certification required for more than 24 visits)	40%; Occupational therapy: 10%	$20	10%
Diabetes Services						
Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies	
Self-management training	$20	60% non-PPO	$20	60% non-PPO	$20	60% non-PPO
Acupuncture						
	$15/visit (acupuncture/chiropractic; combined 20 visits per calender year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calender year)	40%	$20 (10% for all other services)	10%
Chiropractic						
	$15/visit (acupuncture/chiropractic; combined 20 visits per calender year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calender year)	40%	$20/up to 20 visits	10%