

2018 STATE HEALTH PLAN COMPARISON

Active and Non-Medicare Subscribers

PLAN DESIGN FEATURES	80/20 PLAN		70/30 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	\$1,250 Individual \$3,750 Family	\$2,500 Individual \$7,500 Family	\$1,080 Individual \$3,240 Family	\$2,160 Individual \$6,480 Family
Coinsurance	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Medical Coinsurance Maximum	N/A	N/A	\$4,388 Individual \$13,164 Family	\$8,776 Individual \$26,328 Family
Medical Out-of-Pocket Maximum	\$4,350 Individual \$10,300 Family	\$8,700 Individual \$26,100 Family	N/A	N/A
Pharmacy Out-of-Pocket Maximum	\$2,500 Individual \$4,000 Family	\$2,500 Individual \$4,000 Family	\$3,360	
Out-of-Pocket Maximum (Combined Medical and Pharmacy)	\$6,850 Individual \$14,300 Family	\$11,200 Individual \$30,100 Family	N/A	N/A
Affordable Care Act (ACA) Preventive Services	\$0 (covered at 100%)	40% after deductible dependent on service	\$40 for primary doctor; \$94 for specialist	50% after deductible dependent on service
Office Visits	\$25 for primary doctor; \$10 if you use PCP on ID card; \$85 for specialist; \$45 if you use Blue Options Designated specialist	40% after deductible	\$40 for primary doctor; \$94 for specialist	50% after deductible
Urgent Care	\$70	\$70	\$100	\$100

PLAN DESIGN FEATURES	80/20 PLAN		70/30 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Copay waived w/admission or observation stay)	\$300 copay, then 20% after deductible	\$300 copay, then 20% after deductible	\$337 copay, then 30% after deductible	\$337 copay, then 30% after deductible
Inpatient Hospital	\$450 copay, then 20% after deductible; copay not applied if you use a Blue Options Designated Hospital	\$450 copay, then 40% after deductible	\$337 copay, then 30% after deductible	\$337 copay, then 50% after deductible
PRESCRIPTION DRUGS				
Tier 1 (Generic)	\$5 copay per 30-day supply		\$16 copay per 30-day supply	
Tier 2 (Preferred Brand & High-Cost Generic)	\$30 copay per 30-day supply		\$47 copay per 30-day supply	
Tier 3 (Non-preferred Brand)	Deductible/coinsurance		\$74 copay per 30-day supply	
Tier 4 (Low-Cost Generic Specialty)	\$100 copay per 30-day supply		10% up to \$100 per 30-day supply	
Tier 5 (Preferred Specialty)	\$250 copay per 30-day supply		25% up to \$103 per 30-day supply	
Tier 6 (Non-preferred Specialty)	Deductible/coinsurance		25% up to \$133 per 30-day supply	
Preferred Diabetic Testing Supplies **	\$5 copay per 30-day supply		\$10 copay per 30-day supply	
ACA Preventive Medications	\$0	\$0	N/A	N/A

** Preferred Brand are the OneTouch Test Strips. Non-preferred diabetic testing supplies are considered a Tier 3 member copay.