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

| | Healthy Advantage PPO | | EPO Select 20 |
|---|---|---|---|
| **Benefit** | **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 |
| **Preventive Care** | | | |
| 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 |
| **Home/Office/Outpatient Care** | | | |
| 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<br>Testing: Coinsurance<br>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 vists 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 |
| **Inpatient Care** | | | |
| 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 Inpateint vists 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** |
| **Mental Health** | | | |
| 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 |
| **Alcohol/Substance Abuse** | | | |
| 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 |
| **Other** | | | |
| 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 |
| **Prescription Drugs** | | | |
| Retail Program – One copay required for up to a 30-day supply | $50 Deductible per person per calendar year<br>Deductible does not apply to Tier 1 Generic drugs<br>Tier 1/Tier 2/Tier3<br>$10/$20/$40<br><br>Includes Contraceptives (Retail & Mail-Order) | Covered in-network only | $0 Deductible<br><br>Tier 1/Tier 2/Tier3<br>$10/$20/$40<br><br>Includes Contraceptives (Retail & Mail-Order) |
| Mail-Order Program – Only two copays required for a 90-day supply | $0 Deductible<br>The Mail-Order Program has the same copayments as the Retail Program listed above | Covered in-network only | $0 Deductible<br><br>The Mail-Order Program has the same copayments as the Retail Program listed above |
| Routine Vision Care | ***Vision benefits - once every 12 months frequency***<br><br>$5 copay for 1 exam<br><br>$10 eyeglass lense copay<br><br>$115 allowance then 20% off remaining balance for frames<br><br>$75 allowance then 15 % off remaining balance for conventional contacts | $30 allowance for out-of-network exam<br>$64 allowance for pair of frames<br>$25-$35 allowance for lenses | ***Vision benefits - once every 12 months frequency***<br><br>$5 copay for 1 exam<br><br>$10 eyeglass lense copay<br><br>$115 allowance then 20% off remaining balance for frames<br><br>$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.**