

Benefits At-A-Glance

Benefit Description	Carelink Plan 1	Carelink Plan 2	Health Plan Plan A	Health Plan Plan B	PEIA PPB Plans A & B In-Network	PEIA PPB Plans A & B Out-of-Network
Annual deductible	Single - \$200 Family - \$400	Single - \$500 Family - \$1,000	None	\$100 Individual Maximum, \$200 Family Maximum	Varies by salary and employer type. See premium charts.	Twice the in-network deductible
Annual out-of-pocket maximum	Single - \$2,000 Family - \$4,000	Single - \$3,000 Family - \$6,000	Single - \$2,000 Family - \$6,000	Single - \$3,500 Family - \$10,000	Varies by salary & employer type. See premium charts.	Twice the in-network out-of-pocket maximum
PHYSICIAN SERVICES						
Adult routine physical examinations (including prostate and gynecological, with pap smear)	\$0 copay/visit	\$10 copay/visit	PCP - \$15 copay OB/GYN - \$20 copay	PCP - \$15 copay OB/GYN - \$25 copay deductible waived	\$10 co-pay for office visit	Deductible + 40%
Diagnostic x-ray, lab and testing	Deductible: 20% coinsurance	Deductible: 20% coinsurance	20% coinsurance	20% coinsurance after deductible	Deductible + 20%	Deductible + 40%
Mammograms	Covered in Full	Covered in Full	Covered in full unless associated with an office visit	Covered in full unless associated with an office visit deductible waived	Covered in full	Deductible + 40%
Physician inpatient visits	Deductible: 20% coinsurance	Deductible: 20% coinsurance	Covered in full	Covered in full after deductible	Deductible + 20%	Deductible + 40%
Physician office visits - primary care	\$10 copay/visit	\$10 copay/visit	\$15 copay / visit	\$15 copay / visit deductible waived	\$15 co-pay office visit only	Deductible + 40%
Physician office visits - specialty care	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit	\$25 copay / visit deductible waived	\$20 co-pay office visit only	Deductible + 40%
Prenatal care	\$0 copay/visit	\$30 copay for initial visit only; then covered at 100%	\$20 copay / initial visit only	\$25 copay / initial visit only deductible waived initial visit only	Covered in full after deductible	Deductible + 40%
Second surgical opinions	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit	\$25 copay / visit deductible waived	\$20 co-pay office visit only	Deductible + 40% coinsurance office visit only
Voluntary sterilization	\$25 copay	\$30 copay	10% coinsurance	15% coinsurance after deductible	Deductible + 20%	Deductible + 40%

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Well child exams	\$0 copay/visit (Birth to age 18)	\$10 copay/visit (Birth to age 18)	\$15 copay / visit	\$15 copay / visit deductible waived	Covered in full	Covered in full
Well child immunizations (birth through 16)	Covered in Full	Covered in full unless with an office visit	Covered in full unless associated with an office visit	Covered in full unless associated with an office visit deductible waived	Covered in full	Covered in full
INPATIENT SERVICES						
Semi-private room; ancillaries; therapy services, x-ray, lab, surgical services, and general nursing care	Deductible: 20% coinsurance	Deductible: \$500 copay, then 20% coinsurance	10% coinsurance	15% coinsurance after deductible	Deductible + 20%	\$500 + deductible and 40%
Inpatient occupational, physical, or speech therapy *	Deductible: 20% coinsurance	Deductible: \$500 copay then 20% coinsurance	10% coinsurance	15% coinsurance after deductible	Deductible + 20%	\$500 + deductible and 40%
Maternity care (delivery)	Deductible: 20% coinsurance	Deductible: \$500 copay then 20% coinsurance	10% coinsurance	15% coinsurance after deductible	Deductible + 20%	\$500 + deductible + 40%
Rehabilitation *	Deductible: 20% coinsurance	Deductible: \$500 copay then 20% coinsurance	Covered in full (days 1-30); 20% coinsurance (days 31+)	Covered in full (days 1-30) after deductible; 20% coinsurance (days 31+)	Deductible + 20%	\$500 + deductible + 40%
Skilled nursing *	Deductible: 50% coinsurance	Deductible: 50% coinsurance	\$35 copay / day	\$35 copay / day after deductible	Deductible + 20%	\$500 + deductible + 40%
HOSPITAL OUTPATIENT SERVICES						
Ambulatory/outpatient surgery	Deductible: 15% coinsurance	Deductible: \$500 copay then 20% coinsurance	10% coinsurance	15% coinsurance after deductible	\$50 + deductible + 20%	\$100 + deductible + 40%
Preadmission testing, diagnostic x-ray and lab	Deductible: 20% coinsurance	Deductible: 20% coinsurance	20% coinsurance	20% coinsurance after deductible	Deductible + 20%	Deductible + 40%
MENTAL HEALTH & CHEMICAL DEPENDENCY BENEFITS						
Outpatient chemical dependency *	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit	\$20 copay / visit deductible waived	Deductible + 20%	Deductible + 40%

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Outpatient mental health *	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit	\$20 copay / visit; deductible waived	Deductible + 20%	Deductible + 40%
Inpatient chemical dependency (including partial hospitalization) *	Deductible: 20% coinsurance	Deductible: \$500 copay then 20% coinsurance	20% coinsurance	20% coinsurance after deductible	Deductible + 20%	\$500 + deductible and 40%
Inpatient detoxification *	Deductible: 20% coinsurance	Deductible: \$500 copay then 20% coinsurance	20% coinsurance	20% coinsurance after deductible	Deductible + 20%	\$500 + deductible and 40%
Inpatient mental health (including partial hospitalization) *	Deductible: 20% coinsurance	Deductible: \$500 copay then 20% coinsurance	20% coinsurance	20% coinsurance after deductible	Deductible + 20%	\$500 + deductible and 40%
OUTPATIENT THERAPIES						
Acupuncture *	Not Covered	Not Covered	Not covered	Not covered	Deductible + 20%	Deductible + 40% ;
Chiropractic *	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit	\$25 copay / visit; deductible waived	Deductible + 20%	Deductible + 40%
Occupational therapy *	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit	\$25 copay / visit; after deductible	Deductible + 20%	Deductible + 40%
Physical therapy *	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit	\$25 copay / visit; after deductible	Deductible + 20%	Deductible + 40%
Speech therapy *	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit	\$25 copay / visit; after deductible	Deductible + 20%	Deductible + 40%
ALL OTHER MEDICAL SERVICES						
Allergy testing and treatment *	Allergy Serum & Injection covered 100% unless w/office visit	Allergy Serum & Injection covered 100% unless w/office visit	\$20 copay / visit for evaluation; treatment covered in full unless associated with an office visit	\$25 copay / visit for evaluation; treatment covered in full unless associated with an office visit deductible waived	Deductible + 20%	Deductible + 40%
Cardiac rehabilitation *	Deductible: 20% coinsurance	Deductible: 20% coinsurance.	\$10 copay / visit	\$10 copay / visit; after deductible	Deductible + 20%	Deductible + 40%

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Dental services - accident related *	\$25 copay/visit	\$30 copay/visit	10% coinsurance	15% coinsurance; after deductible	Deductible + 20%	Deductible + 40%
Dental services - other *	Not Covered	Not Covered	Not covered	Not covered	Impacted teeth only; deductible + 20%	Impacted teeth only; deductible + 40%
Diabetic supplies *	Covered at 100%	Covered at 100%	Certain supplies covered in full	Certain supplies covered in full; deductible waived	Covered under Prescription drug plan	Covered under Prescription drug plan
Durable Medical Equipment (DME) *	50% coinsurance	50% coinsurance	30% coinsurance	30% coinsurance; after deductible	Deductible + 20%	Deductible + 40%
Emergency ambulance (medically necessary)	Deductible; 20% coinsurance	Deductible; 20% coinsurance	\$50 copay / transport	\$50 copay / transport after deductible	Deductible + 20%	Deductible + 40%
Emergency Room Treatment (Non-emergency)	Not Covered	Not Covered	Not covered	Not covered	\$50 + deductible + 20%	\$50 + deductible + 40%
Emergency services (including supplies) *	\$150 copay (copay waived if admitted)	\$150 copay (copay waived if admitted)	\$75 copay / visit (waived if admitted)	\$75 copay / visit (waived if admitted) deductible waived	\$25 + deductible + 20%	\$25 + deductible + 40%
Growth hormone *	Deductible; 20% coinsurance	Deductible; 20% coinsurance	30% coinsurance	30% coinsurance; after deductible	Covered under prescription drug plan	Covered under prescription drug plan
Hearing exam	Covered under well-child benefit only; Covered in full	Covered under well-child benefit only; \$10 office copay applies	Covered in full unless associated with an office visit	Covered in full unless associated with an office visit; deductible waived	Covered under well child benefit only	Covered under well child benefit only
Home health services *	Deductible; 20% coinsurance	Deductible; 20% coinsurance	Covered in full (intermittent skilled care only)	Covered in full after deductible	Deductible + 20%	Deductible + 40%
Home health supplies *	Deductible; 20% coinsurance	Deductible; 20% coinsurance	Covered in full (certain limits apply)	Covered in full after deductible	Deductible + 20%	Deductible + 40%
Hospice *	15% coinsurance	20% coinsurance	Covered in full	Covered in full after deductible	Deductible + 20%	Deductible + 40%

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Infertility services ★ NO PRESCRIPTION COVERAGE.	Deductible: 20% coinsurance; testing up to diagnosis.	Deductible: 20% coinsurance; testing up to diagnosis.	30% coinsurance	30% coinsurance; after deductible	Deductible + 20%	Deductible + 40%
Medical supplies ★	Deductible: 20% coinsurance	Deductible: 20% coinsurance	30% coinsurance	30% coinsurance	Deductible + 20%	Deductible + 40%
Podiatry	\$25 copay/visit	\$30 copay/visit	\$20 copay / visit routine foot care not covered	\$25 copay / visit routine foot care not covered; deductible waived	\$20; surgery- 20%	Deductible + 40%
Prosthetics ★	Deductible: 30% coinsurance	Deductible: 30% coinsurance	30% coinsurance	30% coinsurance after deductible	Deductible + 20%	Deductible + 40%
Pulmonary Rehabilitation ★	Deductible: 20% coinsurance	Deductible: 20% coinsurance	\$10 copay / visit	\$10 copay / visit after deductible	Deductible + 20%	Deductible + 40%
Radiation and chemotherapy	Deductible: 20% coinsurance	Deductible: 20% coinsurance	20% coinsurance	20% coinsurance after deductible	Deductible + 20%	Deductible + 40%
TMJ ★	20% coinsurance; \$1,000 max per year	20% coinsurance; \$1,000 max per year	30% coinsurance	30% coinsurance after deductible	Not covered	Not Covered
Transplants (non-experimental) ★	Deductible: 20% coinsurance	Deductible: \$500 copay; then 20% coinsurance	10% coinsurance	15% coinsurance after deductible	Deductible + 20%	Deductible + 40%; additional \$10,000 deductible
Urgent Care	\$50 copay/visit	\$50 copay/visit	\$50 copay / visit (waived if admitted)	\$50 copay / visit (waived if admitted) deductible waived	Deductible + 20%	Deductible + 40%
Vision services	Routine Exam - \$25 copay; Corrective lenses up to \$100 reimbursement; once every 12 months. (VSP provider network)	Routine Exam - \$30 copay; Corrective lenses up to \$100 reimbursement; once every 12 months. (VSP provider network)	Not covered	Not covered	Not covered	Not Covered
Lifetime maximum	\$1,000,000	\$1,000,000	\$1,000,000 combined for all HP products	\$1,000,000 combined for all HP products	\$1,000,000	\$1,000,000

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Prescription Drug Benefits

Prescriptions	Carelink Plan 1	Carelink Plan 2	Health Plan Plan A	Health Plan Plan B	PEIA PPB Plan A In-Network	PEIA PPB Plan A Out-of-Network	PEIA PPB Plan B In-Network	PEIA PPB Plan B Out-of-Network
Deductible	None	None	None	None	\$75 individual/ \$150 family	\$75 individual/ \$150 family	\$150 individual/ \$300 family	\$150 individual/ \$300 family
Generic copayment	\$5 copay	\$5 copay	\$10 copayment	\$5 copayment	\$5	\$5 + \$3.00 out of network fee	\$5	\$5 + \$3.00 out of network fee
Formulary brand	\$25 copay	\$25 copay	Not covered if generic is available. 50% coinsurance if generic is not available	Not covered	\$15	\$15 + \$3.00 out of network fee	\$20	\$20 + \$3.00 out of network fee
Non-Formulary Brand	\$60 copay	\$60 copay	Not covered	Not covered	\$50	\$50 + \$3.00 out of network fee	\$50	\$50 + \$3.00 out of network fee
Maintenance Medication discount program details	90-day supply for: one (1) copay for Generic, two (2) copays for Brand, three (3) copays for Non-Formulary, through mail order program. See exclusion list.	90-day supply for: one (1) copay for Generic, two (2) copays for Brand, three (3) copays for Non-Formulary, through mail order program. See exclusion list.	90-day supply \$20 or 50% copayment	90-day supply \$10 copayment	90-day supply for two months' co-pay	No discount	90-day supply for two months' co-pay	No discount
Annual benefit maximum (per member/year)	\$5,000 (applies to Tier 2 and Tier 3 only; no limit for Tier 1)	\$5,000 (applies to Tier 2 and Tier 3 only; no limit for Tier 1)	\$5,000	\$5,000	None	None	None	None
Other details	Over-the-counter nicotine replacement products covered at the Tier 1 copay with prescription. (patches, gum, lozenges)	Over-the-counter nicotine replacement products covered at the Tier 1 copay with prescription. (patches, gum, lozenges)	Mandatory generics Formulary brand name drugs are not covered if generic is available Non formulary drugs are not covered	Mandatory generics Brand name drugs are not covered	\$1,750 individual/ \$3,500 family	\$1,750 individual/ \$3,500 family	\$1,750 individual/ \$3,500 family	\$1,750 individual/ \$3,500 family