

2027 STATE HEALTH PLAN COMPARISON

ACTIVE and NON-MEDICARE Subscribers

	STANDARD PPO Plan				PLUS PPO Plan			
	Preferred	Access	Non-Preferred	Out-of-Network	Preferred	Access	Non-Preferred	Out-of-Network
Annual Deductible	\$1,500 Ind \$4,500 Fam	\$3,000 Ind \$9,000 Fam	\$5,000 Ind \$15,000 Fam	\$15,000 Ind \$45,000 Fam	\$1,000 Ind \$3,000 Fam	\$1,500 Ind \$4,500 Fam	\$4,000 Ind \$12,000 Fam	\$12,000 Ind \$36,000 Fam
Out-of-Pocket Maximum (combined medical & pharmacy)	\$4,000 Ind \$12,000 Fam	\$6,500 Ind \$16,300 Fam	\$12,000 Ind \$24,000 Fam	\$36,000 Ind \$72,000 Fam	\$3,000 Ind \$9,000 Fam	\$5,000 Ind \$15,000 Fam	\$10,000 Ind \$20,000 Fam	\$30,000 Ind \$60,000 Fam
	In-Network (deductible & OOP max cross-accumulates)				In-Network (deductible & OOP max cross-accumulates)			
MEDICAL BENEFITS								
Preventive	\$0 Preventive Services				\$0 Preventive Services			
Primary Care Provider (PCP)	\$15 Preferred PCP listed on ID card \$40 other PCP listed on ID card \$50 other PCP			50% after deductible	\$10 PCP Preferred PCP listed on ID card \$30 other PCP listed on ID card \$40 other PCP			40% after deductible
Walk-In Clinic	\$40 other PCP on ID card \$50 other PCP			50% after deductible	\$30 other PCP on ID card \$40 other PCP			40% after deductible
Specialist	\$40	\$65	30% after deductible	50% after deductible	\$25	\$50	20% after deductible	40% after deductible
Behavioral Health	\$15			50% after deductible	\$10			40% after deductible
Speech, Occupational, Chiropractic, Physical Therapy	\$62			50% after deductible	\$42			40% after deductible
High-Cost Imaging	\$400	30% after deductible	\$1,000, then 30% after ded	50% after deductible	\$250	20% after deductible	\$500, then 20% after ded	40% after deductible
Urgent Care	\$100				\$70			
Emergency Room	\$600, then 30% after deductible (copay waived with admission)				\$500, then 20% after deductible (copay waived with admission)			
Inpatient Hospital	\$750**	\$600, then 30% after ded	\$1,500, then 30% after ded	50% after deductible	\$500**	\$500, then 20% after ded	\$1,000, then 20% after ded	40% after deductible
Outpatient Surgery	\$600**	\$350, then 30% after ded	\$1,000, then 30% after ded	50% after deductible	\$300**	\$300, then 20% after ded	\$500, then 20% after ded	40% after deductible
Ambulatory Surgical Center	\$400**	30% after deductible	\$1,000, then 30% after ded	50% after deductible	\$250**	20% after deductible	\$500, then 20% after ded	40% after deductible
Lantern	Lantern Surgical Benefit \$0 Member Cost				Lantern Surgical Benefit \$0 Member Cost			

** Facility copay only. Additional cost-share may apply.

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PHARMACY BENEFITS		
Rx Tier 1	\$25	\$15
Rx Tier 2	\$75	\$55
Rx Tier 3	Deductible / Coinsurance	Deductible / Coinsurance
Rx Tier 4	\$200	\$100
Rx Tier 5	\$600	\$500
Rx Tier 6	Deductible / Coinsurance	Deductible / Coinsurance
Preferred Blood Glucose Meters and Supplies*	\$10*	\$5*
Preferred & Non-Preferred Insulin	\$0	\$0
Preventive Medications	\$0	\$0

Rx copays for 30-day supply.

*This does not include Continuous Glucose Monitoring Systems or associated supplies. These are considered a Tier 2 member copay.