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 ACA LIMIT $24,000 Fam ACA LIMIT	$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 (deducitble & OOP max cross-accumulates)				*In-Network (deducitble & 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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	STANDARD PPO Plan	**PLUS PPO** Plan
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.