PPO and CDHP Plan Comparison

The PPO and CDHP plan comparison is a summary of the care covered by the PPO plan and CDHP plan and the amounts you pay if you receive care by an in-network provider (see definition below). This comparison does not go into all the details of your coverage. Please see your Summary Plan Description for more information.

DEFINITIONS:

Deductible: The total amount you pay in each calendar year before the plan starts to make payments for covered healthcare costs. You pay down the deductible with each claim. Some services are not subject to the deductible.

	PPO Plan		CDHP Plan	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Individual deductible	$500	Shared with in-network	$1,100	Shared with in-network
Family deductible	$1,500	Shared with in-network	$2,200	Shared with in-network

Out-of-pocket maximum: This is the most you pay each calendar year, including copays, deductibles and co-insurance (the percentage you pay of the allowed amount).

	PPO Plan		CDHP Plan	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Individual out-of-pocket maximum	$2,000	None	$3,200	None
Family out-of-pocket maximum	$6,000	None	$6,400	None

In-network providers: The PPO and CDHP plan are preferred provider plans, which means that the plan provides you benefits for covered services from providers of your choice. You have lower out-of-pocket expenses when you receive care from in-network providers. In-network providers are providers in Premera's Heritage network in Washington, Premera Blue Cross Blue Shield of Alaska, Wyoming's Host Blue's Traditional, and the Host Blue's PPO network for all other states.

Allowed amount: This is the most this plan allows for a covered service. It is often lower than the provider's billed charge.

This is not a complete explanation of covered services, exclusions, or limitations. Please review your Summary Plan Description for a complete explanation of the medial benefit. We have made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this summary and the Summary Plan Description, the Summary Plan Description and other legal documents will govern.

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**PPO IN-NETWORK PROVIDERS**	**CDHP IN-NETWORK PROVIDERS**
Acupuncture		
• Office and Clinic Visits calendar year visit limit: None	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Visits outside an office setting	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Allergy Testing and Treatment	No charge	$1,100 deductible, then 20% coinsurance
Ambulance	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Blood Products and Services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Cellular Immunotherapy and Gene Therapy	Covered as any other in-network service	Covered as any other in-network service
Chemotherapy and Radiation Therapy		
Professional and facility services	No charge	$1,100 deductible, then 20% coinsurance
Clinical Trials Covers routine patient care during the trial	Covered as any other in-network service	Covered as any other in-network service
Dental Care		
• **Dental Anesthesia** (up to age 19 when medically necessary)		
• Inpatient facility care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Outpatient surgery center	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Anesthesiologist		
• **Dental Injury**		
• Exams to determine treatment needed	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Treatment	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Diagnostic X-Ray, Lab, And Imaging for medical conditions or symptoms		
Tests, lab, imaging and scans		
• Advanced Complex Imaging diagnostic services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Diagnostic mammography	No charge	$1,100 deductible, then 20% coinsurance
• Other professional diagnostic imaging/laboratory/pathology, including non-preventive diagnostic colonoscopies	No charge	$1,100 deductible, then 20% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT PPO IN-NETWORK PROVIDERS	CDHP IN-NETWORK PROVIDERS
Dialysis For permanent kidney failure. See the ***Dialysis*** benefit for details.		
• During Medicare's waiting period	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• After Medicare's waiting period	No charge	No charge
Emergency Room	$100 copay per visit, then 0% coinsurance, deductible waived. The copay is waived if you are admitted as an inpatient through the emergency room. The copay is waived if you are transferred and admitted to a different hospital directly from the emergency room.	
• Facility charges You may have additional costs for other services.		$1,100 deductible, then 20% coinsurance
• Professional services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Foot Care such as trimming nails or corns, when medically necessary due to a medical condition		
• In an office or clinic	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• All other settings	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Home Health Care calendar year visit limit: 130 visits		
• Home visits • Prescription drugs billed by the home health agency	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies		
• Sales tax for covered items • Foot orthotics limit: 1 pair per calendar year Therapeutic shoes: 1 pair per calendar year (unlimited when diabetes related) • Medical vision hardware	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Hospice Care Lifetime limit for terminal illness: 6 months; for non-terminal illness, such as palliative care: none Inpatient stay limit: None Home visits: Unlimited Respite care: 240 hours		
• Inpatient facility care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Home and respite care		

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT PPO IN-NETWORK PROVIDERS	CDHP IN-NETWORK PROVIDERS
• Prescription drugs billed by the hospice		
Hospital • Inpatient Care • Professional • Facility • Outpatient Care • Professional • Facility	 $500 deductible, then 20% coinsurance $500 deductible, then 20% coinsurance $500 deductible, then 20% coinsurance $500 deductible, then 20% coinsurance	 $1,100 deductible, then 20% coinsurance $1,100 deductible, then 20% coinsurance $1,100 deductible, then 20% coinsurance $1,100 deductible, then 20% coinsurance
Human Growth Hormone	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Infusion Therapy	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Mastectomy and Breast Reconstruction • Office and clinic visits • Surgery and other professional services • Inpatient facility care	 $25 copay per visit, deductible waived $500 deductible, then 20% coinsurance $500 deductible, then 20% coinsurance	 $1,100 deductible, then 20% coinsurance $1,100 deductible, then 20% coinsurance $1,100 deductible, then 20% coinsurance
Maternity Care Care during pregnancy, childbirth and after the baby is born. See the ***Preventive Care*** benefit for routine exams and tests during pregnancy. Abortion is also covered. • Professional care • Inpatient hospital, birthing centers and short-stay hospitals	 $500 deductible, then 20% coinsurance $500 deductible, then 20% coinsurance	 $1,100 deductible, then 20% coinsurance $1,100 deductible, then 20% coinsurance
Medical Foods includes phenylketonuria (PKU)	No charge	$1,100 deductible, then 20% coinsurance
Medical Transportation Travel and lodging are covered for travel related to covered transplants up to the IRS limitations. Prior approval is required. Limit per transplant: $7,500	 $500 deductible, then 0% coinsurance	 $1,100 deductible, then 0% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT PPO IN-NETWORK PROVIDERS	CDHP IN-NETWORK PROVIDERS
See the ***Ambulance*** benefit for emergency medical transportation coverage.		
Mental Health Care		
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Other professional services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Inpatient and residential facility care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Outpatient facility care	No charge	$1,100 deductible, then 20% coinsurance
Neurodevelopmental Therapy (Habilitation) See the ***Mental Health Care*** benefit for therapies for mental conditions such as autism.		
• Outpatient care calendar year visit limit: 30 visits		
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Other outpatient services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Inpatient care calendar year day limit: 30 days	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Newborn Care		
• Inpatient care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Other outpatient services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Orthognathic Surgery (Jaw Augmentation or Reduction) lifetime limit: None		
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Surgery and other professional care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Outpatient surgery facility care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Inpatient hospital care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Prescription Drug In no case will you pay more than the cost of the drug or supply.		

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT PPO IN-NETWORK PROVIDERS	YOUR SHARE OF THE ALLOWED AMOUNT CDHP IN-NETWORK PROVIDERS
Covered Drugs	**Retail Pharmacy**	**Retail Pharmacy**
• Generic drugs	$10 copay	$1,100 deductible, then 20% coinsurance
• Preferred brand name drugs	$25 copay	
• Non-preferred brand name drugs	$50 copay	
	Mail-Order Pharmacy	**Mail-Order Pharmacy**
• Generic drugs	$10 copay	$1,100 deductible, then 20% coinsurance
• Preferred brand name drugs	$50 copay	
• Non-preferred brand name drugs	$100 copay	
Your cost-shares for covered prescription insulin drugs will not exceed $100 per 30-day supply of the drug. The deductible does not apply. Cost-shares for covered prescription insulin drugs apply toward the deductible.		
Specialty Drugs (per prescription or refill). You must use a specialty pharmacy for these drugs to be covered.	Same as retail	$1,100 deductible, then 20% coinsurance
Exceptions	**Retail or Mail Order Pharmacy**	**Retail or Mail Order Pharmacy**
• Needles and syringes purchased with diabetic drugs (diabetic supplies, including over-the-counter supplies, are covered at 100% of the allowed amount)	No charge	No charge
• Certain prescription drugs and generic over-the-counter drugs to break a nicotine habit	No charge	No charge
• Certain preventive prescription drugs	No charge for drugs on the Affordable Care Act's preventive drug list	No charge for drugs on the PV 1 preventive drug list
• Female birth control drugs, devices and supplies (prescription and over the counter). Includes emergency birth control.	No charge	No charge
Preventive Care		
• Preventive exams, including vision and oral health screening for members under 19, diabetes and depression screening	No charge	No charge
• Well-baby (birth up to 3 weeks) and well-child exams (3 weeks to 12 months), including immunizations	No charge	No charge
	No charge	No charge

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT PPO IN-NETWORK PROVIDERS	CDHP IN-NETWORK PROVIDERS
• Fall prevention for members 65 and older • Immunizations in the doctor's office • Flu shots and other seasonal and non-seasonal immunizations at a pharmacy or mass immunizer location • Travel immunizations at a travel clinic or county health department • Health education and training (outpatient), limited to certain health conditions. • Diabetes health education • Nicotine habit-breaking programs • Nutritional counseling and therapy, limited to certain health conditions.	No charge No charge No charge No charge No charge No charge No charge	No charge No charge No charge No charge No charge No charge No charge
• Pregnant women's care (includes breast-feeding support and post-partum depression screening) • Screening tests (includes prostate and cervical cancer screening) • Screening mammograms • Colon cancer screening • Male and female birth control and sterilization. (Vasectomy covered as preventive only if done in a doctor's office under local anesthetic)	No charge No charge No charge No charge No charge	No charge No charge No charge No charge No charge
Private Duty Nursing calendar year limit: $5,000	No charge	No charge
Professional Visits and Services You may have extra costs for other services like lab tests and facility charges. Also see ***Allergy Testing and Treatment*** and ***Therapeutic Injections***. • Office and clinic visits, including surgery in the office and real-time visits using online and telephonic methods with a provider who also maintains a physical location. • Electronic visits (e-visits) • Other professional services *Coverage for office visits throughout*	 $25 copay per visit, deductible waived $25 copay per visit, deductible waived $500 deductible, then 20% coinsurance	 $1,100 deductible, then 20% coinsurance $1,100 deductible, then 20% coinsurance $1,100 deductible, then 20% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT PPO IN-NETWORK PROVIDERS	 CDHP IN-NETWORK PROVIDERS
this plan includes real-time visits via online and telephonic methods with your doctor or other provider (telemedicine) when appropriate. Please also see ***Virtual Care***		
Psychological and Neuropsychological Testing	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Rehabilitation Therapy • Outpatient Care calendar year visit limit: 30 visits No limit for cardiac or pulmonary rehabilitation programs, or similar programs for cancer or other chronic conditions.		
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Other outpatient services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Inpatient Care calendar year day limit: 30 days	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Skilled Nursing Facility Care calendar year day limit: 120 days	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Sleep Studies		
• In the member's home (members 19 or older)	No charge	No charge
• In an outpatient facility	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Spinal and Other Manipulations calendar year visit limit: None	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
Substance Use Disorder		
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Other professional services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Inpatient and residential facility care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Outpatient facility care	No charge	$1,100 deductible, then 20% coinsurance
Surgery (includes anesthesia and blood transfusions) See the ***Hospital*** and ***Surgical Center Care – Outpatient*** benefits for facility charges.	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Surgical Center Care – Outpatient	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Temporomandibular Joint		

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**PPO IN-NETWORK PROVIDERS**	**CDHP IN-NETWORK PROVIDERS**
Disorders (TMJ) Care		
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Other professional services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Inpatient facility care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Therapeutic Injections	No charge	$1,100 deductible, then 20% coinsurance
Transgender Services		
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Other professional services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Inpatient facility care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
Transplants (Includes donor search and donation costs.)		
• Inpatient facility care	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
• Office and clinic visits	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Surgery and other professional services	$500 deductible, then 20% coinsurance	$1,100 deductible, then 20% coinsurance
**All approved transplant centers covered at the in-network level*		
Urgent Care Services at an urgent care center. (See ***Diagnostic X-Ray, Lab, And Imaging*** for tests received while at the center. Your deductible and coinsurance apply to facility charges.)		
• Freestanding urgent care centers	$25 copay per visit, deductible waived	$1,100 deductible, then 20% coinsurance
• Urgent care centers attached to or part of a hospital	$100 copay per visit, then 0% coinsurance, deductible waived	$1,100 deductible, then 20% coinsurance
Virtual Care Access to medical care using virtual methods like secure chat, text, voice or video chat. *Real-time visits via online or telephonic methods with your doctor or other provider are covered under other benefits of this plan.*		

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**PPO IN-NETWORK PROVIDERS**	**CDHP IN-NETWORK PROVIDERS**
Virtual general medical visits	$10 copay, deductible waived	$10 copay, deductible waived
Virtual mental health visits	$10 copay, deductible waived	$10 copay, deductible waived
Virtual substance use disorder visits	$10 copay, deductible waived	$10 copay, deductible waived