



## FY2017 BENEFIT COMPARISON

SERVICE	FIRST STATE BASIC PPO	CDH GOLD	IPA/HMO	COMPREHENSIVE PPO
	<b>IN-NETWORK</b> Deductible: \$500 Individual/\$1,000 Family	<b>IN-NETWORK</b> Deductible: \$1,500 Individual/\$3,000 Family HRA: \$1,250 Individual/\$2,500 Family	<b>IN-NETWORK ONLY</b> Deductible: None	<b>IN-NETWORK</b> Deductible: None
<b>PREVENTIVE MEDICAL SERVICES</b>				
Preventive Medical Services*	100% covered	100% covered	100% covered	100% covered
<b>TREATMENT OF ILLNESS OR INJURY</b>				
PCP Office Visit	90% covered after deductible	90% covered after deductible	\$15 copay per visit	\$20 copay per visit
Specialist Office Visit	90% covered after deductible	90% covered after deductible	\$25 copay per visit	\$30 copay per visit
<b>EMERGENCY SERVICES</b>				
Urgent Care Centers/ Medical Aid Units	\$25 copay per visit	90% covered after deductible	\$15 copay per visit	\$20 copay per visit
Emergency Room	90% covered after deductible	90% covered after deductible	\$150 copay per visit (waived if admitted)	\$150 copay per visit (waived if admitted)
<b>IMAGING AND LAB SERVICES</b>				
X-Ray	90% covered after deductible	90% covered after deductible	\$20 copay per visit	\$20 copay per visit
High Tech Radiology (CT/PET scans, MRI, MRA)	90% covered after deductible	90% covered after deductible	Hospital affiliated - \$35 copay per visit Freestanding (non-Hospital) Facility – 100% covered	Hospital affiliated - \$35 copay per visit Freestanding (non-Hospital) Facility – 100% covered
Laboratory Facility	90% covered after deductible	90% covered after deductible	\$10 copay per visit	\$10 copay per visit

\*Routine physical exams, immunizations and screenings (age and frequency schedules apply)