State of Colorado employees

# A side-by-side comparison of plans.

| | Copay Choice Plus Plan<br>Network/Out-of-network | HDHP with HSA<br>Network/Out-of-network |
|---|---|---|
| **Deductible** | | |
| Employee | $1,500 / $3,000[1] | $1,500 / $4,500 |
| Family[3] | $3,000 / $6,000[1] | $3,000[2] / $9,000[2] |
| **Out-of-pocket maximum** | | |
| Employee | $5,000 / $10,000 | $3,000 / $9,000 |
| Family[3] | $10,000 / $20,000 | $6,000 / $18,000 |
| **Lifetime maximum benefit** | **Unlimited** | **Unlimited** |
| Annual adult physical | 100% / 50% | 100% / 50% |
| Well-child visits | 100% / 50% | 100% / 50% |
| Mammogram | 100% / 50% | 100% / 50% |
| PSA tests | 100% / 50% | 100% / 50% |
| Doctor visit | 100% after $30 copay / 50%[4] | 80%[4] / 50%[4] |
| Specialist visit | 100% after $50 copay / 50%[4] | 80%[4] / 50%[4] |
| Urgent care visit | $75 copay / 50%[4] | 80%[4] / 50%[4] |
| Emergency room | $500 copay | 80%[4] |
| Ambulance | 80%[4] | 80%[4] |
| Outpatient surgery | 80%4 / 50%[4] | 80%[4] / 50%[4] |
| Lab and X-ray | Preventive: 100% / 50%<br>Diagnostic: 80%[4] / 50%[4] | Preventive: 100% / 50%<br>Diagnostic: 80%[4] / 50%[4] |
| Hospital stay | 80% after $1,000 copay per inpatient stay[6] / 50%[4] | 80%[4] / 50%[4] |
| Mental health services | Outpatient at 100% after a $30 copay per visit / 50%[4] | 80%[4] / 50%[4] |
| Vision exam (once per plan year) | 100% after $50 copay / Not covered | 80%[4] / Not covered |
| Vision benefit frames or standard lenses<br>(once every 24 months) | Frames $130 allowance or contact lens $150 allowance<br>* Allowances apply to in-network providers only. Please refer to your plan details for out-of-network allowances. | Frames $130 allowance or contact lens $150 allowance<br>* Allowances apply to in-network providers only. Please refer to your plan details for out-of-network allowances. |
| Pharmacy | Retail (up to a 31-day supply)<br>Tier 1 $10<br>Tier 2 $30<br>Tier 3 $50<br>Mail Order[5] (up to a 90-day supply)<br>Tier 1 $20<br>Tier 2 $60<br>Tier 3 $100 | Copays apply after you've reached your deductible<br>Retail (up to a 31-day supply)<br>Tier 1 $10<br>Tier 2 $30<br>Tier 3 $50<br>Mail Order[5] (up to a 90-day supply)<br>Tier 1 $20<br>Tier 2 $60<br>Tier 3 $100 |

**Note: Visit welcometouhc.com/colorado for a prescription drug list as well as additional pharmacy information.**

[1] Co-pay Choice Plus Plan: Any deductible amounts satisfied during the last 3 months of the plan year ending June 30, will be carried over to the new plan year. [2] HDHP with HSA: The family deductible maximum (which applies to Employee + Spouse, Employee + Children and Family) must be satisfied before benefits are paid for any individual family member. [3] Employee plus spouse/same-gender domestic partner/child or children/family. [4] After you've reached your deductible. [5] Only certain prescription drugs are available through mail order; please visit our pre-member website at www.welcometouhc.com/colorado for more information. [6] Network deductible does not apply

For more information about deductibles, call Customer Care at 1-877-283-5424. This information is a brief, general description of your coverage, is not a contract and does not replace your Summary of Benefits. For a complete list of your coverage, including exclusions and limitations relating to your coverage, please read your Summary of Benefits. If descriptions, percentages and dollar amounts conflict with official benefit coverage documents, the official benefit coverage documents prevail. Co-payments do not apply to deductible. Co-payments and co-insurance apply to out-of-pocket maximum.

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