2020 Benefit Comparison - Summary

Core PPO Plan

Effective 1/1/2020	Core PPO	
	In-Network	Out-of-Network
Annual Deductible *(Carry-over for claims after Oct 1)*	$500 Individual $1000 Family Aggregate	$ 1000 Individual $2000 Family Aggregate
Supplemental Accident Benefit:	$500 per accident	$500 per accident
Physician Services Family Practice, General Practice, Internal Medicine and Pediatrician	$20 office visit copay, 100% Eligible services (billed and rendered in the office setting)	60% after deductible
Preventive Care	100% - No deductible **ALL** Mammograms and Colonoscopies are covered 100%	
Out-Patient Prenatal Care	100% not subject to ded.	60% after deductible
Specialist	80% after deductible	60% after deductible
Hospital Services	80% after deductible	60% after deductible
Physician Services	80% after deductible	60% after deductible
Mental Health 10 visits - per calendar year - inpatient 50 visits - per calendar year - outpatient **Substance Abuse** Limit-2 admissions per lifetime for drug/alcohol admissions	80% after In-Network deductible	
Prescriptions (ProAct) Use any pharmacy, pay only the co-pay for covered medications. See hendrix.edu/hr for a formulary	**Specialty Drugs—20% of prescription cost up to a MAXIMUM of $250** **$50.00 Non-Preferred** **$30.00 Preferred** **$10.00 Generic Brand** **OTC Claritin & Prilosec (Presc. From Phys. = $0)** **3 mo routine maint. for 2 co-pays at 3 local pharmacies**	
Out-of Pocket Maximum	$5,500 individual $11,000 family aggregate	$10,000 individual $20,000 family aggregate

Premiums - Core PPO Plan

Core PPO Monthly				
	SS/DS	A/F >30k	Others	SLT
EE	$112	$170	$216	$237
EE+SP	$237	$355	$455	$498
EE+CH	$197	$296	$379	$415
EE+FAM	$338	$508	$649	$711

Core PPO Bi-Weekly				
	SS/DS	A/F >30k	Others	SLT
EE	$51.69	$78.46	$99.69	$109.38
EE+SP	$109.38	$163.85	$210.00	$229.85
EE+CH	$90.92	$136.62	$174.92	$191.54
EE+FAM	$156.00	$234.46	$299.54	$328.15

Core PPO Plan participants are eligible to participate in Flexible Spending Account (FSA). The 2020 maximum contribution for an unreimbursable medical FSA is $2,750.
Core plan participants are **NOT** eligible to participate in the Health Savings Account (HSA).

Authorized local pharmacies (3 mo./2 co-pays):	
Baker Drugs	Front Street 329-5626
The Medicine Shoppe	College Ave. 327-8088
Smith Family Pharmacy	Dave Ward Dr. 336-8188

High Deductible HDHP

	High Deductible QHDHP	
	In-Network	Out-of-Network
Annual Deductible - EE Only	$1500 Deductible	$4000 Deductible
Annual Deductible - All Other Coverage Levels	$2800 Deductible	$8000 Family Deductible
No deductible carry-over on HDHP plan		
Physician Services Family Practice, General Practice, Internal Medicine and Pediatrician	**After annual deductible:** $30 office visit copay, 100% Eligible services (billed and rendered in the office setting)	60% after deductible
Preventive Care	100% - No deductible Includes **preventative** mammograms and colonoscopies	
Out-Patient Prenatal Care	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Hospital Services	80% after deductible	60% after deductible
Physician Services	80% after deductible	60% after deductible
Mental Health 10 visits - per calendar year - inpatient 50 visits - per calendar year - outpatient **Substance Abuse** Limit-2 admissions per lifetime for drug/alcohol admissions	80% after In-Network deductible	
Out-of Pocket Maximum - EE ONLY COVERAGE	$6,500 - EE only coverage	$10,000 - EE only coverage
Out-of Pocket Maximum - All other coverages	$8,000 individual /$11,000 family aggregate	$30,000 - all other coverage levels
		After annual in-network deductible
Prescriptions (ProAct) Use any pharmacy, pay only the co-pay for covered medications. See hendrix.edu/hr for a formulary	**Copays AFTER annual in-network deductible is met.**	Specialty Drugs - 20% of cost up to MAXIMUM of $250 $50.00 Non-Preferred $30.00 Preferred $10.00 Generic Brand OTC Claritin & Prilosec, $0 w/ script 3 mo maint rx for 2 mo copay @ local

Premiums - HDHP Plan

High Deductible HDHP Monthly				
	SS/DS	A/F >30k	Others	SLT
EE	$73	$116	$155	$177
EE+SP	$150	$240	$320	$355
EE+CH	$125	$200	$270	$310
EE+FAM	$208	$335	$455	$500

High Deductible HDHP Bi-Weekly				
	SS/DS	A/F >30k	Others	SLT
EE	$33.69	$53.54	$71.54	$81.69
EE+SP	$69.23	$110.77	$147.69	$163.85
EE+CH	$57.69	$92.31	$124.62	$143.08
EE+FAM	$96.00	$154.62	$210.00	$230.77

The High Deductilbe plan is a Qualified High Deductible plan. Participants in this plan may participate in a Health Savings Account (HSA) or a Flexible Spending Account (FSA).
The 2020 HSA maximum contribution for EE Only = $3550; all other = $7,100.

Authorized local pharmacies (3 mo./2 co-pays):	
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Smith Family Pharmacy	Dave Ward Dr. 336-8188

updated 11/6/2019