

Benefit	PPO Plans – IIP: 10015, 10003, 10004, 10005, 10006, 10007		PPO Plans – IIP: 10009, 10010, 10011, 10012	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Calendar Year Deductible (Deductible must be met before payments are made)	IIP10015 = \$250 IIP10003 = \$500 IIP10004 = \$750 IIP10005 = \$1,000 IIP10006 = \$1,500 IIP10007 = \$2,000 3X family	IIP10015 = \$500 IIP10003 = \$1,000 IIP10004 = \$1,500 IIP10005 = \$2,000 IIP10006 = \$3,000 IIP10007 = \$4,000 3X family	IIP10009 = \$750 IIP10010 = \$1,000 IIP10011 = \$1,500 IIP10012 = \$2,000 3X family	IIP10009 = \$1,500 IIP10010 = \$2,000 IIP10011 = \$3,000 IIP10012 = \$4,000 3X family
Annual Out-of-Pocket Maximum (Does not include Deductible)	\$2,000 3X family	\$6,000 3X family	\$4,500 3X family	\$10,000 3X family
Lifetime Maximum Benefit	\$5 million combined In-network and Out-of-network			
Maximum Lifetime Hospice Benefit	\$7,500 combined In-network and Out-of-network			
Maximum Lifetime Transplant Benefit ⁽¹⁾ Must use PIC approved facilities	Subject to Maximum Lifetime Benefit	Not Covered	Subject to Maximum Lifetime Benefit	Not Covered
Pre-Existing Limitation (Does not apply to pregnancy, newborns and newly adopted children)	<ul style="list-style-type: none"> No pre-existing limitation if prior creditable coverage New Hires: 6/6 Late Enrollees: 6/18 			
Physician Services Non-Specialist office visits Specialist office visits Outpatient Surgery (In Physician's office) Specialty Pharmaceuticals ⁽¹⁾ (Injectible forms administered in Physician's office) Allergy Services Testing Serum (extracts) Injections	\$20 Copay/visit ^(2,3) \$30 Copay/visit ^(2,3) 20% 15% up to a maximum of \$250 per injection and \$1,500 per Calendar Year 20% 20% 20%	40% 40% 40% 15% up to a maximum of \$250 per injection 40% 40% 40%	\$30 Copay/visit ^(2,3) \$40 Copay/visit ^(2,3) 30% 15% up to a maximum of \$250 per injection and \$1,500 per Calendar Year 30% 30% 30%	50% 50% 50% 15% up to a maximum of \$250 per injection 50% 50% 50%
Clinical Preventive Services such as, but not limited to: Routine Physicals Adult Immunizations Child Immunizations Well Child Care Pap Smear Mammography Colonoscopy	\$20 Copay/visit ^(2,3) \$20 Copay/visit ^(2,3) \$20 Copay/visit ^(2,3) \$20 Copay/visit ^(2,3) \$20 Copay/visit ^(2,3) \$0 Copay ⁽²⁾ \$0 Copay ⁽²⁾	40% 40% 40% 40% 40% 40% 40%	\$30 Copay/visit ^(2,3) \$30 Copay/visit ^(2,3) \$30 Copay/visit ^(2,3) \$30 Copay/visit ^(2,3) \$30 Copay/visit ^(2,3) \$0 Copay ⁽²⁾ \$0 Copay ⁽²⁾	50% 50% 50% 50% 50% 50% 50%
Women's Healthcare Gynecological Care In office/Obstetrical/Maternity Care Delivery ⁽¹⁾	\$20 Copay/visit ^(2,3) \$20 Copay/visit ^(2,3) 20% ⁽¹⁾	40% 40% 40%	\$30 Copay/visit ^(2,3) \$30 Copay/visit ^(2,3) 30%	50% 50% 50%
Diabetes Services Diabetes Education and Office Visits (OV)	Included in OV Copay	40%	Included in OV Copay	50%

⁽¹⁾Benefit Certification may be required. ⁽²⁾Not subject to or counted toward Deductible ⁽³⁾Copayment is for the office visit **only**.

All other services received during the office visit are subject to Deductible and Coinsurance.

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Benefit	PPO Plans – IIP: 10015, 10003, 10004, 10005, 10006, 10007		PPO Plans – IIP: 10009, 10010, 10011, 10012	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Outpatient Services				
Surgeries ⁽¹⁾	20%	40%	30%	50%
Diagnostic Tests: X-Ray ⁽¹⁾	20%	40%	30%	50%
Diagnostic Tests: Lab	\$0	40%	\$0	50%
Hospital Inpatient Services ⁽¹⁾				
Room & Board	20%	40%	30%	50%
Inpatient Physician Care	20%	40%	30%	50%
Hospice Care ⁽¹⁾	20%	40%	30%	50%
Accidental Injury/Urgent/Emergency Care				
Emergency Care including trauma	20%	20% Initial treatment only 40% follow-up care	30%	30% Initial treatment only 50% follow-up care
Urgent Care	\$30 ⁽³⁾	\$30 ⁽³⁾ Initial treatment only 40% follow-up care	\$40 ⁽³⁾	\$40 ⁽³⁾ Initial treatment only 50% follow-up care
Ambulance Services	20%		30%	
Complementary Therapies				
Acupuncture (\$1,500/Calendar Year maximum)	20%	Not Covered	30%	Not Covered
Chiropractic Services (\$1,500/Calendar Year maximum)	20%	Not Covered	30%	Not Covered
Mental Health Services ⁽¹⁾				
Outpatient	\$30 Copay/visit ^(2,3)	40%	\$40 Copay/visit ^(2,3)	50%
Inpatient/Partial Hospitalization	20%	40%	30%	50%
Rehabilitation Services				
Cardiac and Pulmonary Rehabilitation	20%	40%	30%	50%
Occupational, physical and speech therapy ⁽¹⁾ (up to two months per condition per Calendar Year)	20%	40%	30%	50%
Durable Medical Equipment, Prosthetics, Appliances ⁽¹⁾	20%	40% (\$1,000/Calendar Year Maximum-Diabetic supplies do not count toward the Calendar Year Maximum benefit.)	30%	50% (\$1,000/Calendar Year Maximum-Diabetic supplies do not count toward the Calendar Year Maximum benefit.)
Transplants ⁽¹⁾	20%	Not Covered	30%	Not Covered
Prescription Drugs ^(1,2)				
Generic (Preferred)	\$10		\$10	
Brand (Preferred)	\$35		\$35	
Brand when generic is available	Generic copay + cost difference	Not Covered (Must use a participating pharmacy)	Generic copay + cost difference	Not Covered (Must use a participating pharmacy)
Non-Preferred	\$55		\$55	
Diabetic supplies Brand/Generic/Non-Preferred	\$10 / \$35 / \$55		\$10 / \$35 / \$55	
Prepackaged items Brand/Generic/Non-Preferred	\$10 / \$35 / \$55		\$10 / \$35 / \$55	
Specialty Pharmaceuticals ⁽¹⁾	15% up to \$250 per prescription and \$1,500 per Calendar Year		15% up to \$250 per prescription and \$1,500 per Calendar Year	
Alcohol/Substance Abuse ⁽¹⁾				
Detoxification Only	20%	40%	30%	50%

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