PPO MEDICAL BENEFITS

Medical Benefit Highlights	DISCONTINUED PLAN		NEW PLAN	
	PPO Plan In-Network Grandfathered	PPO Plan Out-of-Network Grandfathered	PPO Plan In-Network	PPO Plan Out-of-Network
Annual Deductible				
Individual	$300	$1,000	$500	$1,000
Family	$900	$3,000	$900	$3,000
Annual Out-of-Pocket Maximum				
Individual	$2,000 (including deductible)	$3,000 (including deductible)	$2,500 (including deductible)	$3,000 (including deductible)
Family	$4,000 (including deductible)	$9,000 (including deductible)	$4,000 (including deductible)	$9,000 (including deductible)
Lifetime Maximum Benefit (per person)	Unlimited		Unlimited	
Preventive Care Services (No co-payment, deductible or co-insurance) **Below are some examples of services*:**	85% (for select lab tests & x-rays only)	70%	100%	
Laboratory Services	85% (routine labs, specimens and blood work are covered, subject to deduction/co-insurance)			
Well Baby/Child Visits	Not Covered		100%	
Immunizations/Vaccinations	Not Covered		100%	
Maternity and Newborn Care	85%, subject to deductions/ co-insurance			
Physician Services				
Office Visit, Primpary Care Physician	85%	70%	80% (after $10 copay)	70%
Office Visit, Specialist Physician	85%	70%	80% (after $20 copay)	70%
Hospital Services** Inpatient or Outpatient	85%	70%	80% (after $100 copay)	70% (after $100 copay)
Emergency Room Visit	85% (after $100 copay)	70% (after $100 copay)	80% (after $175 copay)	80% (after $175 copay)
*PPO members must contact the Medical Services Advisory (MSA) at least 1 business day prior to a non-emergency hospital admission and within 2 business days of an emergency or maternity ospital admission; otherwise, an additional $500 copay applies. **There is no copay for outpatient preventive endoscopic surgical procedures such as colonoscopies.				
Mental Health Services				
Inpatient	85%	70%	80%	70%
Outpatient	85%	70%	80% (after $100 copay)	70% (after $100 copay)
Chemical Dependency Services				
Inpatient	85%	70%	80%	70%
Outpatient	85%	70%	80% (after $100 copay)	70% (after $100 copay)
Other Covered Services (e.g., physical therapy, home health care)	85%	70%	80%	70%
Prescription Drugs Carved Out to CVS/Caremark				
Prescription Drugs Retail (30 day supply)				
Generic Copay	$10	Reimbursed at 75% of network rate minus $10 copay	$10	Reimbursed at 75% of network rate minus $10 copay
Brand Formulary Copay	$20	Reimbursed at 75% of network rate minus $20 copay	$20	Reimbursed at 75% of network rate minus $20 copay
Brand Non-Formulary Copay	$40	Reimbursed at 75% of network rate minus $40 copay	$40	Reimbursed at 75% of network rate minus $40 copay
Mail Order (90 day supply)				
Generic Copay	$20	Reimbursed at 75% of network rate minus $20 copay	$20	Reimbursed at 75% of network rate minus $20 copay
Brand Formulary Copay	$40	Reimbursed at 75% of network rate minus $40 copay	$40	Reimbursed at 75% of network rate minus $40 copay
Brand Non-Formulary Copay	$80	Reimbursed at 75% of network rate minus $80 copay	$80	Reimbursed at 75% of network rate minus $80 copay
If you choose a non-formulary drug when a generic is available, you pay the cost difference between them in addition to the copay.				

This sheet only highlights the benefit plans. For additional information, contact the District Office of Human Resources, Benefits Division.