



Schedule of Benefits

July 1, 2024 to June 30, 2025

We Are Here For **PEIA!**

Plans A, B (HMO) & C (POS)



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| Benefit Description | Plan A | Plan B | Plan C (POS) |
|--|---|--|--|
| Annual Deductible | \$600/\$1,200 Goes towards OOP Max | \$1,000/\$2,000 Goes towards OOP Max | <u>IN</u> : \$1,200/\$2,400 <u>OUT</u> : \$2,400/\$4,800 Goes towards OOP Max |
| Annual Out-of-Pocket Maximum <i>*Includes Rx copays</i> | Single: \$6,850 Two person: \$13,700 Family: \$13,700 <i>*Includes Rx copays</i> | Single: \$ 6,850 Two person: \$13,700 Family: \$13,700 <i>*Includes Rx copays</i> | <u>IN</u> : Single: \$6,850 Two person: \$13,700 Family: \$13,700 <u>OUT</u> : Single: \$10,000 Two person: \$20,000 Family: \$20,000 <i>*Includes Rx copays</i> |

Physician Services

| | | | |
|--|---|---|---|
| Adult Routine Physical Examinations <i>(including prostate and gynecological, with PAP smear)</i> | Covered in full per healthcare reform | Covered in full per healthcare reform | <u>IN</u> : Covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible |
| Diagnostic X-ray, Lab and Testing | 20% co-insurance after deductible | 30% co-insurance after deductible | <u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Mammograms | Routine covered in full per healthcare reform | Routine covered in full per healthcare reform | <u>IN</u> : Routine covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible |
| Physician Inpatient Visits | 15% co-insurance after deductible | 30% co-insurance after deductible | <u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Physician Office Visits – Primary Care | \$10 copay/visit deductible waived | \$10 copay/visit deductible waived | <u>IN</u> : \$10 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible |
| Physician Office Visits – Specialty Care | \$40 copay/visit deductible waived | \$40 copay/visit deductible waived | <u>IN</u> : \$40 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible |



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| Prenatal Care | \$40 copay initial visit only deductible waived | \$40 copay initial visit only deductible waived | <u>IN</u> : \$40 copay initial visit only deductible waived <u>OUT</u> : 40% co-insurance after deductible |
| Second Surgical Opinions | \$40 copay/visit deductible waived | \$40 copay/visit deductible waived | <u>IN</u> : \$40 copay/ visit deductible waived <u>OUT</u> : 40% co-insurance after deductible |
| Voluntary Sterilization | Men 30% co-insurance after deductible Women covered in full per healthcare reform | Men 30% co-insurance after deductible Women covered in full per healthcare reform | <u>IN</u> : Male 30% co-insurance after deductible <u>OUT</u> : Male 40% co-insurance after deductible <u>IN</u> : Female covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible |
| Well-Child Exams | Covered in full per healthcare reform | Covered in full per healthcare reform | <u>IN</u> : Covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible |
| Well-Child Immunizations (birth through 16) | Covered in full per healthcare reform | Covered in full per healthcare reform | <u>IN</u> : Covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible |
| Inpatient Services | | | |
| Semi-private Room; Ancillary; Therapy Services, X-ray, Lab, Surgical Services, and General Nursing Care | \$100 copay + 15% co-insurance after deductible | \$100 copay + 30% co-insurance after deductible | <u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Inpatient Occupational, Physical, or Speech Therapy | \$100 copay + 15% co-insurance after deductible | \$100 copay + 30% co-insurance after deductible | <u>IN</u> : \$100 + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |



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| Maternity Care (delivery) | \$100 copay + 15% co-insurance after deductible | \$100 copay + 30% co-insurance after deductible | <u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Rehabilitation | Visit 1-30: \$0 copay/visit after deductible 31+ visits: 20% visit after deductible | Visit 1-30: \$0 copay/visit after deductible 31+ visits: 30% visit after deductible | <u>IN</u> : Visit 1-30: \$0 Copay/visit after deductible 31+ visits: 30% coinsurance <u>OUT</u> : 50% after deductible |
| Skilled Nursing | \$35 copay/day after deductible | \$35 copay/day after deductible | <u>IN</u> : \$35 copay/day after deductible <u>OUT</u> : 40% co-insurance after deductible |
| Hospital Outpatient Services | | | |
| Ambulatory/Outpatient Surgery | \$100 copay + 15% co-insurance after deductible | \$100 copay + 30% co-insurance after deductible | <u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Pre-admission Testing, Diagnostic X-ray and Lab | 20% co-insurance after deductible | 30% co-insurance after deductible | <u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Mental Health & Chemical Dependency Benefits | | | |
| Outpatient Chemical Dependency | \$10 copay/visit deductible waived | \$10 copay/visit deductible waived | <u>IN</u> : \$10 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible |
| Outpatient Mental Health | \$10 copay/visit deductible waived | \$10 copay/visit deductible waived | <u>IN</u> : \$10 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible |



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| Inpatient Chemical Dependency <i>(including partial hospitalization)</i> | \$100 copay + 15% co-insurance/ admission after deductible | \$100 copay + 30% co-insurance/ admission after deductible | <u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Inpatient Detoxification | \$100 copay + 15% co-insurance/admission after deductible | \$100 copay + 30% co-insurance/admission after deductible | <u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Inpatient Mental Health <i>(including partial hospitalization)</i> | \$100 copay + 15% co-insurance/admission after deductible | \$100 copay + 30% co-insurance/admission after deductible | <u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Outpatient Therapies | | | |
| Acupuncture | Not covered | Not covered | Not covered |
| Chiropractic | \$10 copay/visit deductible waived | \$10 copay/visit deductible waived | <u>IN</u> : \$10 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible |
| Occupational Therapy | Visit 1-20: \$10 copay/visit | Visit 1-20: \$10 copay/visit | <u>IN</u> : Visits 1-20: \$10 copay/visit <u>OUT</u> : 40% co-insurance/visit after deductible |
| Physical Therapy | Visit 1-20: \$10 copay/visit | Visit 1-20: \$10 copay/visit | <u>IN</u> : Visits 1-20: \$10 copay/visit <u>OUT</u> : 40% co-insurance/visit after deductible |
| Speech Therapy | Visit 1-20: \$10 copay/visit | Visits 1-20: \$10 copay/visit | <u>IN</u> : Visits 1-20: \$10 copay/ visit <u>OUT</u> : 40% co-insurance/ visit after deductible |



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| All Other Medical Services | | | |
| Allergy Testing and Treatment | \$40 copay/visit after deductible | \$40 copay/visit after deductible | <u>IN</u> : \$40 copay/visit after deductible <u>OUT</u> : 40% co-insurance/visit after deductible |
| Cardiac Rehabilitation | \$10 copay/visit after deductible | \$10 copay/visit after deductible | <u>IN</u> : \$10 copay/visit after deductible <u>OUT</u> : 40% co-insurance/visit after deductible |
| Dental Services – Accident Related | \$100 copay + 15% after deductible | \$100 copay + 30% after deductible | <u>IN</u> : \$100 copay +30% after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Dental Services – Other | Not covered | Not covered | Not covered |
| Diabetic Supplies | \$0 copay deductible waived | \$0 copay deductible waived | <u>IN</u> : \$0 copay deductible waived <u>OUT</u> : 40% co-insurance after deductible |
| Dialysis | 20% co-insurance/visit after deductible | 20% co-insurance/visit after deductible | <u>IN</u> : 20% co-insurance/visit after deductible <u>OUT</u> : 40% co-insurance/visit after deductible |
| Durable Medical Equipment (DME) | 30% copay after deductible | 30% copay after deductible | <u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Emergency Ambulance (medically necessary) | \$75 copay/Transport after deductible | \$75 copay/Transport after deductible | <u>IN</u> : \$75 copay/transport after deductible <u>OUT</u> : \$75 copay/transport after deductible |
| Emergency Room Treatment (non-emergency) | Not covered | Not covered | Not covered |
| Emergency Services (including supplies) | \$250 copay/visit waived if admitted Deductible waived | \$250 copay/visit waived if admitted Deductible waived | <u>IN & OUT</u> : \$250 copay/visit waived if admitted Deductible waived |



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| Growth Hormone | Rx benefit: 30% or \$300 whichever is less per specialty drug | Rx benefit: 30% or \$300 whichever is less per specialty drug Generic only | <u>IN</u> : Rx benefit 30% or \$300 whichever is less per specialty drug Generic only |
| Hearing Exam | \$40 copay/visit deductible waived | \$40 copay/visit deductible waived | <u>IN</u> : \$40 copay/visit deductible waived <u>OUT</u> : 40% co-insurance/visit after deductible |
| Home Health Services | \$0 copay after deductible | \$0 copay after deductible | <u>IN</u> : \$0 copay after deductible <u>OUT</u> : 40% co-insurance after deductible |
| Home Health Supplies | \$0 copay after deductible | \$0 copay after deductible | <u>IN</u> : \$0 copay after deductible <u>OUT</u> : 40% co-insurance after deductible |
| Hospice | \$0 copay after deductible | \$0 copay after deductible | <u>IN</u> : \$0 copay after deductible <u>OUT</u> : 40% co-insurance after deductible |
| Infertility Services | Basic Health Care Limitations apply after deductible | Basic Health Care Limitations apply after deductible | <u>IN</u> : Basic Health Care Limitations apply after deductible <u>OUT</u> : Basic Health Care Limitations apply after deductible |
| Medical Supplies | 30% co-insurance Certain limits may apply after deductible | 30% co-insurance Certain limits may apply after deductible | <u>IN</u> : 30% co-insurance Certain limits apply after deductible <u>OUT</u> : 50% co-insurance Certain limits apply after deductible |
| Podiatry | \$40 copay/visit deductible waived | \$40 copay/visit deductible waived | <u>IN</u> : \$40 copay/visit deductible waived <u>OUT</u> : 40% co-insurance/visit after deductible |



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| Prosthetics | 30% co-insurance after deductible | 30% co-insurance after deductible | <u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Pulmonary Rehabilitation | \$10 copay/visit after deductible | \$10 copay/visit after deductible | <u>IN</u> : \$10 copay after deductible <u>OUT</u> : 40% co-insurance after deductible |
| Radiation and Chemotherapy | 20% co-insurance after deductible | 20% co-insurance after deductible | <u>IN</u> : 20% co-insurance after deductible <u>OUT</u> : 40% co-insurance after deductible |
| TMJ | 40% co-insurance/visit after deductible | 40% co-insurance/visit after deductible | <u>IN</u> : 40% After deductible <u>OUT</u> : 50% After deductible |
| Transplants (non-experimental) | \$100 copay + 15% co-insurance after deductible | \$100 copay + 30% co-insurance after deductible | <u>IN</u> : \$100 copay +30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible |
| Urgent Care | \$50 copay/incident deductible waived | \$50 copay/incident deductible waived | <u>IN & OUT</u> : \$50 copay/incident deductible waived |
| Vision Services | Not covered | Not covered | Not covered |



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| Prescription Drug Benefits | | | |
|---|--|--|--|
| Deductible | None | None | None |
| Generic Copayment | \$10 copay | \$10 copay | \$10 copay |
| Formulary Brand | 50% copay if generic is NOT available | Not covered | Not covered |
| Non-Formulary Brand | Not covered | Not covered | Not covered |
| Maintenance Medication Discount Program Details | 90-day supply mail order \$20 generic or 50% brand formulary if no generic | 90-day supply generic ONLY \$20 copay | 90-day supply generic ONLY \$20 copay |
| Annual Benefit Maximum (per member/year) | None Out-of-pocket maximum is combined with medical | None Out-of-pocket maximum is combined with medical | None Out-of-pocket maximum is combined with medical |
| Other Details | Specialty drugs – 30% or \$300 whichever is less per specialty drug | Specialty drugs – 30% or \$300 whichever is less per GENERIC specialty drug | Specialty drugs – 30% or \$300 whichever is less per GENERIC specialty drug |
| Family Planning | Contraceptive injections, IUD, diaphragms and sterilizations (women) covered in full under medical benefit Oral contraceptives – covered in full under Rx benefit per healthcare reform | Contraceptive injections, IUD, diaphragms and sterilizations (women) covered in full under medical benefit Oral contraceptives – covered in full under Rx benefit per healthcare reform | Contraceptive injections, IUD, diaphragms and sterilizations (women) covered in full under medical benefit Oral contraceptives – covered in full under Rx benefit per healthcare reform |
| Hearing Aids | Not covered | Not covered | Not covered |
| Lifetime Maximum | Unlimited | Unlimited | Unlimited |

When services are limited to a maximum number of days, treatments, visits, etc., each visit, treatment, etc. must be medically necessary and appropriate to be covered.

