

## PRE-EXISTING CONDITION INSURANCE PLAN BENEFITS COMPARISON OF CA-PCIP TO FEDERAL BENCHMARK PLAN

TYPE OF SERVICE	CA-PCIP COST SHARING		LIMITATIONS AND EXPLANATIONS	FEDERAL COST SHARING		LIMITATIONS AND EXPLANATIONS
	IN-NETWORK	OUT-OF-NETWORK		IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible	<b>\$1,500</b>	<b>\$3,000</b>	Separate in-network and out-of-network deductible	<b>\$2,000</b>	<b>\$3,000</b>	Separate in-network and out-of-network deductible
Coinsurance	<b>15%</b>	<b>50%</b>	Coinsurance for services provided in-network is based on the Plan Allowance. Coinsurance for services provided out-of-network is 50% of the Plan Allowance plus any additional provider charges.	<b>30%</b>	<b>50%</b>	
Annual Out-Of-Pocket Maximum	<b>\$2,500</b>	<b>No Limit</b>	Includes in-network medical and brand name prescription drug deductibles, in-network copayments and coinsurance. There is no out-of-pocket maximum for services received out-of-network.	<b>\$6,250</b>	<b>\$10,000</b>	Includes in-network deductibles, copays and coinsurance apply to the in-network out-of-pocket maximum and are applied to help satisfy the out-of-network catastrophic (out-of-pocket) maximum.
Preventive Care	<b>0%</b>	<b>50%*</b>	In-network preventive care services are not subject to a deductible, copayment, or coinsurance. If you receive preventive care services from an out-of-network provider, you will have to pay any out-of-network deductible that you have not met and then 50% of the Plan Allowance plus any additional provider charges.	<b>0%</b>	<b>50%*</b>	In-network preventive care services are not subject to a deductible, copayment, or coinsurance. If you receive preventive care services from an out-of-network provider, you will have to pay any out-of-network deductible that you have not met and then 50% of the Allowance plus any additional provider charges. Out-of-network preventive care for children is covered under medical care, subject to the deductible.

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	IN-NETWORK	OUT-OF-NETWORK		IN-NETWORK	OUT-OF-NETWORK	
Doctor Office Visit	\$25	50%*	\$25 copayment for in-network office visits. In-network office visits are not subject to the annual deductible but do count towards the annual out-of-pocket maximum.	\$25	50%*	\$25 copayment for in-network office visits. In-network office visits are not subject to the annual deductible but do count towards the annual out-of-pocket maximum.
Doctor Inpatient Visit	15%*	50%*		30%*	50%*	
Inpatient Hospital Services	15%*	50%*	Prior authorization is required. You must contact PCIP within 24 hours of an emergency admission.	30%*	50%*	Prior authorization is required. Failure to get precertification results in \$500 penalty
Outpatient Hospital Services	15%*	50%*	Prior authorization is required for certain surgical procedures.	30%*	50%*	Prior authorization is required for certain surgical procedures.
Emergency Services	15%*	15%*	Limited to treatment of a medical emergency.	30%*	50%*	
Ambulance	15%*	15%*	Limited to a transport during a medical emergency. The in-network deductible, coinsurance, and out-of-pocket maximum apply to emergency services received from an in-network or out-of-network provider.	30%*	50%*	
Surgery & Anesthesia	15%*	50%*	Prior authorization is required for certain surgical procedures.	30%*	50%*	Prior authorization is required for certain surgical procedures.
Organ Transplants	15%*	50%*	Some transplants must be performed in a Center of Expertise to receive the in-network benefit. Prior authorization is required.	30%*	50%*	Some transplants must be performed in plan designated facility to receive maximum benefits. Prior authorization is required
Outpatient Diagnostic X-ray & Laboratory Services	15%*	50%*		30%	50%	Some procedures require pre-authorization

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	IN-NETWORK	OUT-OF-NETWORK		IN-NETWORK	OUT-OF-NETWORK	
Family Planning Services	15%*	50%*	Some birth control products are covered under the prescription drug benefit.	30%*	50%*	Oral Contraceptives are covered under the Rx benefit
Pregnancy, Maternity, and Newborn Care	15%*	50%*	Includes prenatal care, delivery services and postpartum care for the mother.	30%*	50%*	
Infusion Therapy	15%*	50%*		30%*	50%*	
Physical Therapy	15%*	50%*		30%*	50%*	Limited to 60 visits per calendar year for physical/occupational therapy combined. Prior authorization required.
Occupational Therapy	15%*	50%*	Prior authorization is required.	30%*	50%*	
Speech Therapy	15%*	50%*	Prior authorization is required.	30%*	50%*	Limited to 30 visits per calendar year. Prior authorization required.
Skilled Nursing Facility	15%*	50%*	Services are available only when determined to be a medically appropriate alternative plan of treatment that is cost effective. Prior authorization is required.	Benefits limited to \$700 per day	Benefits limited to \$700 per day	Limited to first 14 days following transfer from acute inpatient confinement when skilled care is still required.
Home Health Care	15%*	50%*	Prior authorization is required.	30%*	All charges*	Limited to 25 in-home visits per calendar year
Hospice Care	15%*	50%*	Prior authorization is required.	None*	None*	Benefits limited to \$15,000. Combined inpatient and outpatient limit
Durable Medical Equipment	15%*	50%*	Prior authorization is required for certain durable medical equipment.	30%	All charges	Pre-certification required.
Orthotics and Prosthetics	15%*	50%*		30%*	50%*	

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	IN-NETWORK	OUT-OF-NETWORK		IN-NETWORK	OUT-OF-NETWORK	
<b>Inpatient Mental Health Care Services</b>	<b>15%*</b>	<b>50%*</b>	Inpatient treatment of Serious Emotional Disturbances (SED) of a child and Severe Mental Illness (SMI) has no day limits. All other inpatient mental health care is limited to 10 days each calendar year. Prior authorization is required.	<b>30%*</b>	<b>50%*</b>	No visit limits-cost sharing is equal to medical benefits, if provided in an authorized treatment plan.
<b>Outpatient Mental Health Care Services</b>	<b>15%*</b>	<b>50%*</b>	Outpatient treatment of Serious Emotional Disturbances (SED) of a child and Severe Mental Illness (SMI) has no visit limits. All other outpatient mental health care is limited to 15 visits each calendar year.	<b>\$25</b>	<b>50%*</b>	No visit limits-cost sharing is equal to medical benefits if provided in an authorized treatment plan.
<b>Inpatient Alcohol and Substance Abuse Treatment</b>	<b>15%*</b>	<b>50%*</b>	Services are covered to remove toxic substances from the system. Prior authorization is required.	<b>30%*</b>	<b>50%*</b>	No visit limits-cost sharing is equal to medical benefits if provided in an authorized treatment plan.
<b>Outpatient Alcohol and Substance Abuse Treatment</b>	<b>15%*</b>	<b>50%*</b>	Limited to 20 visits each calendar year. Additional visits may be available with prior authorization.	<b>\$25</b>	<b>50%*</b>	No visit limits-cost sharing is equal to medical benefits if provided in an authorized treatment plan.

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PRESCRIPTION DRUG	CA-PCIP COST SHARING			LIMITATIONS AND EXPLANATIONS
	IN-NETWORK CVS/CAREMARK		OUT-OF-NETWORK	
	Retail	Mail		
Annual Brand Name Drug Deductible	<b>\$500</b>		<b>\$500</b>	Separate in-network and out-of-network deductibles.
Generic Copayment	<b>\$5</b>	<b>\$5</b>	<b>50%</b>	No annual deductible.
Preferred Brand Name Copayment	<b>\$15*</b>	<b>\$15*</b>	<b>50%*</b>	In-network: if a generic drug exists, the cost is \$5 plus the difference between the brand name and generic drug, unless the doctor indicates "dispense as written" or by receiving prior authorization from PCIP.
Non-Preferred Brand Name Copayment	<b>\$30*</b>	<b>\$30*</b>	<b>50%</b>	
Specialty Drugs (30 Day Supply)	<b>N/A</b>	<b>\$30*</b>	<b>N/A</b>	Requires prior authorization.
Maximum supply (days)	<b>30</b>	<b>90</b>	<b>30</b>	Maximum supply for specialty drugs is 30 days.

\* The annual brand name prescription drug deductible applies.

PRESCRIPTION DRUG	FEDERAL COST SHARING				LIMITATIONS AND EXPLANATIONS
	FORMULARY		NON-FORMULARY		
	Retail	Mail	Retail	Mail	
Rx Deductible	<b>\$500</b>		<b>\$750</b>		Separate deductibles for formulary and non-formulary.
Generic Copayment First Two Fills	<b>\$4</b>	<b>\$10</b>	<b>\$4</b>	<b>\$10</b>	Annual deductible applies.
Generic Copayment 3 <sup>rd</sup> Fill and After	<b>Greater of \$4 or 50%</b>	<b>Greater of \$4 or 50%</b>	<b>Greater of \$4 or 50%</b>	<b>Greater of \$4 or 50%</b>	
Brand Name First Two Fills	<b>\$40</b>	<b>\$100</b>	<b>\$80</b>	<b>\$200</b>	
Brand Name 3 <sup>rd</sup> Fill and After	<b>Greater of \$40 or 50%</b>	<b>N/A</b>	<b>All Charges</b>	<b>N/A</b>	
Specialty Drugs (30 Day Supply)	<b>25% to \$150 max</b>		<b>50% to \$300 max</b>		
Specialty Drugs (90 Day Supply)		<b>25% to \$350 max</b>		<b>50% to \$500 max</b>	
Maximum supply (days)	<b>30</b>	<b>90</b>	<b>30</b>	<b>90</b>	