

**PRE-EXISTING CONDITION INSURANCE PLAN**

**BENEFITS COMPARISON OF CA-PCIP TO FEDERAL PCIP**

The attached chart provides a comparison of current benefits provided in the CA-PCIP with the benefits covered in the federal program. Coverage for major categories of benefits is similar in both programs, differences are found in the cost-sharing provisions. Transitioning subscribers will be subject to deductibles and out-of-pocket maximum in the federal program at one-half of the annual limits in addition to whatever amounts they have paid in CA-PCIP.

Medical Deductible	\$1,000.00
Pharmacy Deductible (Formulary)	\$250.00
Out-of-Pocket Maximum	\$3,125.00

More detailed benefits information and a copy of the plan brochure and benefits summary can be found at <http://www.pciplan.com>

**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	\$1,500	\$3,000	Separate in-network and out-of-network deductible	\$2,000	\$3,000	Separate in-network and out-of-network deductible
Coinsurance	15%	50%	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.	30%	50%	
Annual Out-Of-Pocket Maximum	\$2,500	No Limit	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.	\$6,250	\$10,000	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	0%	50%*	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.	0%	50%*	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.

\*Annual Deductible Applies

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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%*	Limited to 30 visits per calendar year. Prior authorization required.
Speech Therapy	15%*	50%*	Prior authorization is required.	30%*	50%*	Limited to first 14 days following transfer from acute inpatient confinement when skilled care is still 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 25 in-home visits per calendar year
Home Health Care	15%*	50%*	Prior authorization is required.	30%*	All charges*	Benefits limited to \$15,000. Combined inpatient and outpatient limit
Hospice Care	15%*	50%*	Prior authorization is required.	None*	None*	Pre-certification required.
Durable Medical Equipment	15%*	50%*	Prior authorization is required for certain durable medical equipment.	30%	All charges	
Orthotics and Prosthetics	15%*	50%*		30%*	50%*	

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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	\$500		\$500	Separate in-network and out-of-network deductibles.
Generic Copayment	\$5	\$5	50%	No annual deductible.
Preferred Brand Name Copayment	\$15*	\$15*	50%*	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	\$30*	\$30*	50%	
Specialty Drugs (30 Day Supply)	N/A	\$30*	N/A	Requires prior authorization.
Maximum supply (days)	30	90	30	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	\$500		\$750		Separate deductibles for formulary and non-formulary.
Generic Copayment First Two Fills	\$4	\$10	\$4	\$10	Annual deductible applies.
Generic Copayment 3 <sup>rd</sup> Fill and After	Greater of \$4 or 50%	Greater of \$4 or 50%	Greater of \$4 or 50%	Greater of \$4 or 50%	
Brand Name First Two Fills	\$40	\$100	\$80	\$200	
Brand Name 3 <sup>rd</sup> Fill and After	Greater of \$40 or 50%	N/A	All Charges	N/A	
Specialty Drugs (30 Day Supply)	25% to \$150 max		50% to \$300 max		
Specialty Drugs (90 Day Supply)	25% to \$350 max		50% to \$500 max		
Maximum supply (days)	30	90	30	90	