VPC Benefits Consortium

All Plans are Non-Grandfathered	Plan 4 - PPO	Plan 6 - PPO High Deductible
Deductible	$500/$1,000	$1,500/$3,000 (not embedded)
Out-of-Pocket Maximum: Medical (includes copays and coinsurance)	$3,000/$6,000 (deductible is included)	$3,000/$6,000 (includes deductible and Rx)
Lifetime Maximum	Unlimited	Unlimited
Inpatient Hospital (per admission)	20% after deductible	20% after deductible
Skilled Nursing (limited to 100 day maximum per confinement)	20% after deductible	20% after deductible
Home Health Care	No Charge	20% after deductible
Hospice	No Charge	20% after deductible
Outpatient Surgery	20% after deductible	20% after deductible
Professional Services (surgeon, radiologist, pathologist, anesthesiologist, etc.)	Providers Office: Covered under office visit copay if performed same day. Facility and all other: 20% after deductible.	20% after deductible
Second Surgical Opinion	$20/$40 not subject to deductible	20% after deductible
Diagnostic Lab/X-Ray (non complex)	Providers Office: Covered under office visit copay if performed same day Facility: 20% after deductible	20% after deductible
Complex Diagnostic - MRIs, MRA, CAT, PET CT, MRS and other complex scans	20% after deductible	20% after deductible
PCP Office Visit	$20 not subject to deductible	20% after deductible
Specialist Office Visit	$40 not subject to deductible	20% after deductible
Preventive Care	0% not subject to deductible	0% not subject to deductible
Immunizations/Well Baby Care	0% not subject to deductible	0% not subject to deductible
Allergy Testing	$20/$40 not subject to deductible	20% after deductible
Allergy Shots/Serum	No Charge (If services are billed with an office visit charge, the office visit copay will apply)	20% after deductible
Shots and Therapeutic Injections	20% after deductible	20% after deductible
Maternity	Initial visit to confirm pregnancy: $40 copayment to OB or $20 copayment to PCP A PCP/Specialist copay will be assessed for each visit to a provider that is not the OB Diagnostic testing and ultrasounds: $40 per visit for diagnostic testing; Inpatient: 20% of the allowable charge after deductible; if OB bills globally OP services will be covered at 20% after deductible	20% of the allowable change after the deductible is met for OB services; IP coverage at 20% after deductible

VPC Benefits Consortium

All Plans are Non-Grandfathered	Plan 4 - PPO	Plan 6 - PPO High Deductible
Emergency Room	20% after deductible	20% after deductible
Urgent Care	$20/$40 not subject to deductible	20% after deductible
Durable Medical Equipment (No Max) (Prosthetics covered with no limit)	20% after deductible	20% after deductible
Spinal Manipulation (30 visits per CY)	$40 not subject to deductible	20% after deductible
Occupational, Physical and Speech Therapy (30 office visit limit per CY combined for OT and PT; separate 30 visit limit per CY for speech)	$30 not subject to deductible	20% after deductible
Mental & Nervous Disorders		
Inpatient (no limit)	20% after deductible	20% after deductible
Outpatient (no limit)	Office Visit: $20 (from $40); Outpatient Facility: 100% after deductible (was 20% after ded)	20% after deductible
Substance Abuse		
Inpatient (no limit)	20% after deductible	20% after deductible
Outpatient (no limit)	Office Visit: $20 (from $40); Outpatient Facility: 100% after deductible (was 20% after ded)	20% after deductible
Vision Exam (limited to 1 every 12 months) Blue View Vision	$15 not subject to deductible	$15 not subject to deductible
Prescription Drug (4th tier coinsurance added for specialty medications; preventive drug rider added to all plans - certain preventive medications will be covered at no cost to the member)	$150/$300 ded on tiers 2 and 3 Retail: $10/$40/$60/20% up to $200 per script maximum (from $10/$35/$55) Mail Order: $10/$80/$120/20% up to $400 per script maximum (from $10/$70/$110)	20% after deductible
Out-of-Pocket Maximum: Rx (includes copays and coinsurance)	$3,600/$7,200	See above
Out of Network		
Deductible	$500/$1,000 (not combined with in-network deductible)	$1,500/$3,000 (not embedded)
Coinsurance	30%	30%
OOP Maximum	$4,500/$9,000 (not combined with in-network)	$4,000/$8,000 (not combined with in-network)

Not Embedded means the first listed limit applies if employee-only coverage is elected; the second listed limit applies if a spouse or any dependents are also covered. There is no lesser limit per covered life.
Disclaimer: The benefit booklet will govern the final claim payment process for the above benefits.