Compare Benefits & Cost

Basic Plans (PPO & Association Plans)

For more details about the benefits provided by a specific plan, refer to that plan's ***Evidence of Coverage*** (EOC) booklet.

All benefits subject to regulatory approval.

	PPO Basic Plans				Association Plans				
	PERS Gold		PERS Platinum		CAHP		PORAC		CCPOA
Benefits	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	EPO
Calendar Year Deductible									
Individual	$1,000 [1,3]	$2,500 [3]	$500 [3]	$2,000 [3]	N/A		$300	$600	N/A
Family	$2,000 [1,3]	$5,000 [3]	$1,000 [3]	$4,000 [3]	N/A		$900	$1,800	N/A
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)									
Individual	$3,000 (coinsurance)	Unlimited	$2,000 (coinsurance)	Unlimited	$3,000 (coinsurance)	Unlimited	$2,000	$2,000	$1,500 (pharmacy included in copay)
Family	$6,000 (coinsurance)	Unlimited	$4,000 (coinsurance)	Unlimited	$6,000 (coinsurance)	Unlimited	$4,000	$4,000	$4,500 (pharmacy included in copay)
Hospital (including Mental Health and Substance Abuse)									
Deductible (per admission)	N/A		$250 (copay)		N/A		N/A		N/A
Inpatient	20% [2]	40% [4]	10%	40% [4]	10%	Varies	20%	20% [4]	$100/admission
Outpatient Facility/ Surgery Services	20%	40% [4]	10%	40% [4]	10%	40% [4]	20%	20% [4]	$50

[1] Incentives available to reduce individual inpatient deductible (max. $500) or family deductible (max. $1,000). Refer to EOC for details.
[2] Coinsurance waived for deliveries if enrolled in Included Health's Maternity Program by the 24th week of pregnancy.
[3] Deductible is not transferable between PERS Gold and PERS Platinum.
[4] Of the allowable amount as defined in the EOC.

Continued on next page

Benefits	PPO Basic Plans				Association Plans				
	PERS Gold		PERS Platinum		CAHP		PORAC		CCPOA
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	EPO
Emergency Services									
Emergency Room	$50 (applies to hospital emergency room facility charge only)		$50 (applies to hospital emergency room charges only)		$50 (copay reduced to $25 if admitted on an inpatient basis)		N/A		N/A
Emergency	20% (applies to other services such as physician, X-ray, lab, etc.)		10% (applies to other services such as physician, X-ray, lab, etc.)		10% (applies to other services such as physician, X-ray, lab, etc.)		20%		$75
Non-Emergency	20%	40%	10%	40%	$50+10%	$50+40%	50% (for non-emergency services provided by hospital emergency room)		$75 (applies to facility fee; no charge for physician fee)
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(copay reduced to $25 if admitted on an inpatient basis)				
Physician Services (including Mental Health and Substance Abuse)									
Office Visits (copay for each service provided)	$35 [5,6]	40% [7]	$20 [6]	40% [7]	$20 [5]	40% [7]	$10/$35 [6]	20% [7]	$15
Inpatient Visits	20%	40% [7]	10%	40% [7]	10%	40% [7]	20%	20% [7]	No Charge
Outpatient Visits	$35	40% [7]	$20	40% [7]	10% [9]	40% [7]	20%	20% [7]	$15
Urgent Care Visits	$35	40% [7]	$35	40% [7]	$20 [9]	40% [7]	$35	20% [7]	$15
Preventive Services	No Charge	40% [7]	No Charge	40% [7]	No Charge	40% [7]	No Charge		No Charge
Surgery/Anesthesia	20%	40% [7]	10%	40% [7]	10%	40% [7]	20%	20% [7]	No Charge
Diagnostic X-ray/Lab	20% [8]	40% [7]	10% [8]	40% [7]	10%	40% [7]	20%	20% [7]	No Charge

[5] Reduced to $10 when seen by matched primary physician.
[6] $35 for specialist visit.
[7] Of the allowable amount as defined in the EOC.
[8] For lab services only — no charge when using Quest Diagnostic or Labcorp.
[9] For non-mental health visits only — no charge for visits with a mental health provider.

Basic Plans (PPO & Association Plans), *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's ***Evidence of Coverage*** (EOC) booklet.

All benefits subject to regulatory approval.

	PPO Basic Plans				Association Plans				
	PERS Gold		PERS Platinum		CAHP		PORAC		CCPOA
Benefits	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	EPO
Prescription Drugs									
Deductible	N/A		N/A		N/A		N/A		Tier 2, 3, and 4: $50 (not to exceed $150/family)
Retail Pharmacy (30-day supply)	Tier 1: $5 Tier 2: $20 Tier 3: $50		Tier 1: $5 Tier 2: $20 Tier 3: $50		Generic: $5 Formulary: $20 Non-Formulary: $50		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45		Tier 1: $10 Tier 2: $25 Tier 3 and 4: $50
Retail Pharmacy (90-day supply)	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		Generic: $10 Formulary: $40 Non-Formulary: $100 (Retail Preferred Pharmacy Maintenance Medications)		N/A		Tier 1: $30 Tier 2: $75 Tier 3 and 4: $150 (Retail Preferred Pharmacy Maintenance Medications)
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		Generic: $10 Formulary: $40 Non-Formulary: $100		Generic: $20 Brand Formulary: $40 Non-Formulary: $75	N/A	Tier 1: $20 Tier 2: $50 Tier 3 and 4: $100
Mail order maximum copayment per person per calendar year	$1,000		$1,000		N/A		N/A		N/A
Durable Medical Equipment	20% (pre-certification required for specific equipment)	40%[10]	10% (pre-certification required for the purchase of equipment priced at $1,000 or more)	40%[10]	10%	40%[10]	20%	20%[10]	No Charge

[10] Of the allowable amount as defined in the EOC.

Benefits	PPO Basic Plans				Association Plans				
	PERS Gold		PERS Platinum		CAHP		PORAC		CCPOA
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	EPO
Infertility Testing/Treatment									
January 1–June 30, 2027	50%		50%		10% (Testing only)	40% (Testing only)	50%	50% [13]	50% of Allowed Charges
July 1–December 31, 2027	$35 [11]	N/A	$35 [11]	N/A					
Occupational / Physical / Speech Therapy									
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		10%	40%	20%	20% [13]	No Charge
Outpatient (office and home visits)	20%	40%; Occupational therapy: 20%	10%	40%; Occupational therapy: 10%	10%	40%	20%	20% [13]	No Charge
	(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)				
Diabetes Services									
Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies		No Charge
Self-management training	$20 [12]	40% [13]	$20 [12]	40% [13]	$20	60% [13]	$10 [12]	20% [13]	$15
Acupuncture	$15/visit	40% [13]	$15/visit	40% [13]	10%	40% [13]	20%	20% [13]	N/A
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 30 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		
Chiropractic	$15/visit	40% [13]	$15/visit	40% [13]	10%	40% [13]	20%	20% [13]	$15 exam (up to 20 visits per calendar year) chiropractic appliances benefit: $50
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 30 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		
Pregnancy & Maternity Care	20% [14]	40%	10%	40%	10%	40%	80%	80%	No Charge

[11] Per treatment bundle. Treatment bundles may include medically necessary tests, services, and medication. Services included in treatment bundle may vary by treatment plan. Subject to deductible.

[12] $35 for specialist visit.

[13] Of the allowable amount as defined in the EOC.

[14] Coinsurance waived for deliveries if enrolled in Included Health's Maternity Program by the 24th week of pregnancy.