

**Poudre School District
Medical Plan Comparison August 1, 2023 – July 31, 2024**

| | PPO1 Plan | | PPO2 Plan |
|--|---|---|---|
| Benefit Description | In-Network | Out-of-Network | In-Network Only |
| Plan Year Deductible | Individual: \$500 Family: \$1,500 | Individual: \$750 Family: \$2,250 | Individual: \$1,000 Family: \$3,000 |
| Plan Year Out-of-Pocket Maximum | Individual: \$4,400 Family: \$8,800 | Individual: \$7,400 Family: \$14,800 | Individual: \$7,600 Family: \$15,200 |
| Primary Care Office Visit | \$35 copayment; services billed outside office services are subject to deductible and 30% coinsurance | Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |
| Specialist Office Visit | Plan pays 70%; You pay 30% after deductible | Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |
| Preventive Care Annual Well Exam (age 2 and up) | Plan pays 100% | Plan pays 100% up to \$200/plan year; You pay 50% after deductible | Plan pays 100% |
| Well Child (to age 2) | Plan pays 100% | Plan pays 100% up to \$300/plan year; You pay 50% after deductible | Plan pays 100% |
| Mammograms/Routine Prostate Exams | Plan pays 100% | Plan pays 100% up to \$100/plan year; You pay 50% after deductible | Plan pays 100% |
| Urgent Care | Plan pays 70%; You pay 30% after deductible | If immediate care is required: Plan pays 70%; You pay 30% after deductible If immediate care is not required: Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |
| Inpatient Hospital | Plan pays 70%; You pay 30% after deductible | Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |
| Outpatient/Ambulatory Surgery | Plan pays 70%; You pay 30% after deductible | Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |

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| Benefit Description | PPO1 Plan | | PPO2 Plan |
|--|---|---|---|
| | In-Network | Out-of-Network | In-Network Only |
| Laboratory and X-Ray – Diagnostic MRIs, CAT and PET Scans | Plan pays 70%; You pay 30% after deductible | Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |
| Emergency Care | Plan pays 70%; You pay 30% after deductible | If immediate care is required: Plan pays 70%; You pay 30% after deductible If immediate care is not required: Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |
| Ambulance | Plan pays 70%; You pay 30% after deductible | Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |
| Durable Medical Equipment | Plan pays 70%; You pay 30% after deductible | Plan pays 50%; You pay 50% after deductible; \$2,000 plan year max | Plan pays 70%; You pay 30% after deductible |
| Therapies – Occupational, Physical, Speech | Plan pays 70%; You pay 30% after deductible; 30 sessions maximum per acute care | Plan pays 50%; You pay 50% after deductible; 30 sessions maximum per acute care | Plan pays 70%; You pay 30% after deductible; 30 sessions maximum per acute care |
| Mental Health/Substance Use Disorders – Inpatient Services | Plan pays 70%; You pay 30% after deductible | Plan pays 50%; You pay 50% after deductible | Plan pays 70%; You pay 30% after deductible |
| Mental Health/Substance Use Disorders – Outpatient Services | Plan pays 70%; You pay 30% (does not apply toward the annual deductible) | Plan pays 50%; You pay 50% (does not apply toward the annual deductible) | Plan pays 70%; You pay 30% (does not apply toward the annual deductible) |

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| | | | |
|-------------------------------------|--|----------------|--|
| Prescription Drugs | | | |
| Out-of-Pocket Maximum | Individual: \$1,500 Family: \$3,000 | Not Applicable | Individual: \$1,500 Family: \$3,000 |
| Retail (up to 34-day supply) | Generic: You pay 10% Preferred: You pay 20% Non-Preferred: You pay 30% | No Benefit | Generic: You pay 10% Preferred: You pay 20% Non-Preferred: You pay 30% |
| Mail Order (90-day supply) | Generic: You pay \$25 Preferred: You pay \$75 Non-Preferred: You pay \$125 | No Benefit | Generic: You pay \$25 Preferred: You pay \$75 Non-Preferred: You pay \$125 |

If there is a conflict between the information in this summary and the legal plan documents, the plan will be administered according to the legal plan documents.