		Reading School District
PLAN NAME		**PPON.1 as of 7/1/17**
In-Network		
Coinsurance	Plan Paid %	100%
Coinsurance	Claimant %	0%
Deductible	Individual	$350
Deductible	Family	$700
Out-of-Pocket Maximum	Individual	$1,500
Out-of-Pocket Maximum	Family	$3,000
Out-of-Pocket Maximum	Includes Rx (Y or N)	Yes
Out-of-Pocket Maximum	Includes Deductible (Y or N)	Yes
Out-of-Pocket Maximum	Includes Copays (Y or N)	Yes
Out-of-Network		
Coinsurance	Plan Paid %	80%,70%,50%
Coinsurance	Claimant %	20%,30%,50%
Deductible	Individual	$700
Deductible	Family	$1,400
Out-of-Pocket Maximum	Individual	$6,350
Out-of-Pocket Maximum	Family	$12,700
In-Network Benefits Outside of the Coinsurance (Copays and Limits)		
PCP (Primary) Copay		IN: $15; OON: 80%
SCP (Specialist) Copay		IN: $30; OON: 80%
Preventive Care Screenings/Immunization		**Preventive Care** IN: $0; OON: 80%; Immunization IN: $0; OON: 20%
Diagnostic Lab/X-ray		IN: Deductible; OON: Deductible + 80%
Complex Imaging (CT/PET Scans, MRIs)		IN: Deductible; OON: Deductible + 80%
Emergency Room Copayment		IN & OON: $100 (waived if admitted)
Urgent Care Copay		IN & OON: $40
Ambulance (ground, air, water)		**Emergency:** $0 (Deductible waived) / **Non-Emergency**: IN Deductible; OON: Deductible + 80%
Hospital Inpatient Copay		IN: Deductible; OON: Deductible + 50%
Outpatient Surgery Copay		IN: Deductible; OON: Deductible + 80%
Inpatient Mental Health/Substance Abuse Coverage		IN: Deductible; OON: Deductible + 80% professional, 50% facility
Outpatient Mental Health/Substance Abuse Coverage		IN: $15 (PCP) / $30 (Professional) OON: Deductible + 80% professional, 50% facility
Durable Medical Equipment		IN: Deductible; OON: Deductible + 80%
Prosthetic Devices		IN: Deductible; OON: Deductible + 80%
Home Health Care		IN: Deductible; OON: Deductible + 80%
Hospice		IN: Deductible; OON: Deductible + 70%
Skilled Nursing Care		IN: Deductible; OON: Deductible + 50% (100 days per benefit period)
Chiropractic (spinal manipulation)		IN: $30 + Deductible; OON: Deductible + 80%
Infertility		IN: Deductible; OON: Deductible + 80%
Physical Therapy		IN: $30 + Deductible; OON: Deductible + 80%
Speech Therapy		IN: $30 + Deductible; OON: Deductible + 80% (12 visits per benefit period)
Occupational Therapy		IN: $30 + Deductible; OON: Deductible + 80% (12 visits per benefit period)
Transplant Coverage		**Evaluation, Acquisition and Transplantation**: IN: $0; OON: Deductible + 80%; BDCT: in: $0, $10,000 maximum per transplant episode; OON: Not covered
TMJ (oral and maxillofacial treatment)		Not covered
Routine Eye Exam		Not covered
Routine Hearing Exam		IN: Deductible; OON: Deductible + 80%
Bariatric Surgery Coverage (Obesity treatment)		Not covered except for morbid obesity and medical necessity
Experimental or Investigational Treatment		Not covered
Partial Hospitalization		IN: Deductible; OON: Deductible + 50%
Pre-Admission Testing		IN: Deductible; OON: Deductible + 80%
Clinical Trials		IN: Deductible; OON: Deductible + 80%; with approved clinical trials
PCP visits - Inpatient Hospital Visit or Consultation		IN: Deductible; OON: Deductible + 80%
PCP visits - Allergy Treatment		**Allergy Service**: IN: Deductible; OON: Deductible + 80%
PCP visits - Second Surgical Option		IN: Deductible; OON: Deductible + 80%
PCP visits - Maternity		IN: Deductible; OON: Deductible + 80%
PCP visits - Surgical Services		IN: Deductible; OON: Deductible + 80%
Oral Surgery		IN: Deductible; OON: Deductible + 80%
Acupuncture Treatment		Not covered
Chemotherapy		IN: Deductible; OON: Deductible + 80%
Radiation Therapy		IN: Deductible; OON: Deductible + 80%
Dialysis Treatment		IN: Deductible; OON: Deductible + 80%
Vision Therapy		**Vision Care for Illness or Accidental Injury**: IN: Deductible; OON: Deductible + 80%