



**IPSSA Packages**

<b>Package Descriptions</b>	<b>CPR Package 1</b>	<b>CPR Package 2</b>	<b>CPR Package 3</b>
Compliance Services & Training (BLR)	Included	Included	Included
Health Club Memberships (LA Fitness)	Included	Included	Included
Free Physicians by Phone (Consult-A-Dr)	Included	Included	Included
Add'l Accident Benefits	Included	Included	Included
Add'l Critical Illness Benefits	Included	Included	Included
Major Medical (PHCS Network)	\$5000 Deductible Plan Included	\$2000 Deductible Plan Included	\$750 Deductible Plan Included
Payroll Services (BTAB)	Included	Included	Included
Member Only	\$297.95 - \$397.95	\$392.95 - \$492.95	\$436.95 - \$536.95
Member + Spouse	\$604.40 - \$704.40	\$799.40 - \$899.40	\$890.40 – \$990.40
Member + Child(ren)	\$549.80 - \$649.80	\$699.80 - \$799.80	\$829.80 - \$929.80
Member + Family	\$869.81 - \$969.81	\$1,079.81 - \$1,179.81	\$1,389.81 - \$1,489.81



**IPSSA Major Medical Summaries**

Package Descriptions	CPR Package 1	CPR Package 2	CPR Package 3
Major Medical Summary of In-Network Benefits Included:			
Deductible	\$5,000	\$2,000	\$750
Network	PHCS PPO	PHCS PPO	PHCS PPO
Co-insurance	80% after deductible	80% after deductible	80% after deductible
Doctor Office Visits	\$30(\$60s) Copay	\$25(\$50s) Copay	\$20(\$40s) Copay
Urgent Care Visits	\$75 Copay	\$75 Copay	\$75 Copay
Emergency Room	\$250 Copay	\$250 Copay	\$250 Copay
Prescription Drug	\$20 generic, \$35 brand, \$60 non-preferred brand \$0 Copay for Mail-Order Generics (FREE) 2xCopay for 90 day Non-generics	\$15 generic, \$30 brand, \$55 non-preferred brand \$0 Copay for Mail-Order Generics (FREE) 2xCopay for 90 day Non-generics	\$10 generic, \$25 brand, \$50 non-preferred brand \$0 Copay for Mail-Order Generics (FREE) 2xCopay for 90 day Non-generics
Wellness	\$0 Copay (FREE)	\$0 Copay (FREE)	\$0 Copay (FREE)
Inpatient Care	80% after deductible	80% after deductible	80% after deductible
In-hospital Surgery	80% after deductible	80% after deductible	80% after deductible
Out-Patient Surgery	80% after deductible	80% after deductible	80% after deductible
Maternity Benefit	80% after deductible	80% after deductible	80% after deductible
Diagnostic Lab & X-ray	\$30 Copay	\$25 Copay	\$20 Copay
<p>Standard Member-Only monthly package rates will range from \$297 to \$537.            To see your rates, you must go through the enrollment process and make your selections.            Your enrollment will <u>not</u> be complete until you have re-typed your PIN to accept the benefit election form, and you reach a screen that says "Congratulations!"</p>			

\* CPR membership fees are included in package rates provided. \* CPR reserves the right to allow exceptions on a location-by-location basis.



**IPSSA Dental and Vision Summaries**

<b>Open-Network Benefits</b>			
<u>Class 1 – Diagnostic/Preventative Services</u>		<u>Class III – Major Services (12-month waiting period)</u>	
Exams	100%	Inlays, Onlays and Crowns	50%
Cleanings, Fluoride Treatments, & Sealants	100%	Prosthetics (Bridges, Dentures)	50%
X-Rays (Bitewings Only, All Others)	100%	Surgical Periodontics	50%
Palliative Treatment (Emergency)	100%	Complex Oral Surgery	50%
<u>Class II – Basic Services</u>		<u>Orthodontics (12-month waiting period)</u>	
Space Maintainers	80%	Orthodontics (to age 19)	50%
Basic Restorative	80%	<u>Plan Maximums</u>	
Simple Extractions	80%	Annual Maximum	\$1,000
Endodontics	80%	Child Lifetime Ortho Maximum	\$1,000
Repairs of Crowns, Inlays, Onlays, Dentures and Bridges	80%	<u>Annual Program Deductible (per person/per family)</u>	
Non-Surgical Periodontics	80%	Class II	\$50 / \$150
General Anesthesia	80%	Class III	\$50 / \$150
	Member Only	\$23.70	
	Member with Spouse	\$47.20	
	Member with Child(ren)	\$51.20	
	Member with Family	\$82.60	

- Network is open to all providers. Providers should file claims for you. Standard exclusions and limitations apply.
- Unmarried dependent children covered to age 25. Unmarried dependent students covered to age 25.

<b>VSP Network Vision Benefits</b>	
WellVision Exam	\$10.00 Copay
Prescription Glasses	\$25.00 Copay
Lenses:	Single vision, lined bifocal, and lined trifocal lenses, Scratch-resistant coating, Polycarbonate lenses for dependent children
Frame:	\$130.00 allowance for frame of your choice, 20% off the amount over your allowance
OR Contact Lens Care	No copay. \$130.00 allowance for contacts and the contact lens exam (fitting & evaluation).
	Member Only \$6.80
	Member + Spouse \$10.88
	Member + Child(ren) \$11.10
	Member + Family \$17.90

- Unmarried dependent children covered to age 25. Unmarried dependent students covered to age 25.