

# \$250 Deductible PPO 80/60 \$25 Copay Plan

## Benefits and Coverage Matrix

Deductible <sup>#</sup>		Office Copay	Prescription Drug Program <sup>1*</sup> (including oral contraceptives, diaphragms and covered diabetic drugs and testing supplies)		Calendar Year Copayment Maximum <sup>#</sup>	
Preferred Providers	Non-Preferred Providers		Retail <sup>2</sup> (for up to a 30-day supply)	Mail Order <sup>2</sup> (for up to a 90-day supply)	Preferred Providers	Non-Preferred Providers
\$250 Individual \$500 Family		\$25	\$10 Generic \$25 Formulary Brand \$35 Non-Formulary Brand 30% home self-administered injectable drugs	\$20 Generic \$50 Formulary Brand \$60 Non-Formulary Brand Home self-administered injectable drugs not covered	\$3,000 Individual \$6,000 Family	\$10,000 Individual \$20,000 Family

### LIFETIME MAXIMUMS

\$6,000,000

COVERED SERVICES	MEMBER COPAYMENT	
	Preferred Providers <sup>3</sup>	Non-Preferred Providers <sup>3</sup>
<b>Professional Services</b>		
<b>Physician Services</b>		
– Office visits and consultations	\$25/visit* <sup>4</sup>	40% <sup>#</sup>
– Specialist visits and consultations	\$25/visit* <sup>4</sup>	40% <sup>#</sup>
– Laboratory and X-rays	\$25/visit	40%
– Mammogram and Pap test or other FDA-approved cervical cancer screening tests	\$25/visit*	40%
– Allergy testing or treatment	20% <sup>5</sup>	40%
– Diagnostic Testing	20%	40%
<b>Preventive Care</b>		
– Annual routine physical exam (includes eye/ear screening, immunizations, vaccinations)	\$25/visit* <sup>4</sup>	Not Covered
– Mammogram and Pap test screening or other FDA-approved cervical cancer screening tests	\$25/visit*	Not Covered
– Laboratory	\$25/visit*	Not Covered
<b>Well-Baby Care</b>		
– Office visits and consultations (includes eye/ear screening, immunizations, vaccinations)	\$25/visit* <sup>4</sup>	Not Covered
– Laboratory	\$25/visit	Not Covered
<b>OUTPATIENT SERVICES</b>		
– Outpatient surgery in hospital/facility	\$50 <sup>#</sup> /surgery + 20% <sup>5</sup>	40% <sup>6</sup>
– Outpatient treatment, renal dialysis and necessary supplies	20% <sup>5</sup>	40% <sup>6#</sup>
<b>HOSPITALIZATION SERVICES</b>		
– Inpatient physician visits and consultations	20% <sup>5</sup>	40% <sup>6</sup>
– Surgeons and assistants, anesthesiologists, pathologists, radiologists	20% <sup>5</sup>	40% <sup>6</sup>
– Semi-private room and board, medically necessary services (including subacute care) and supplies	\$100 per admission + 20% <sup>5</sup>	40% <sup>6</sup>
<b>EMERGENCY HEALTH COVERAGE</b>		
– Facility services (waived if admitted directly to the hospital as an inpatient)	\$50** + 20%*	\$50** + 20%*
– Emergency room physician services	20%	20%
<b>AMBULANCE SERVICES</b>	20%	20%
<b>DURABLE MEDICAL EQUIPMENT</b>		
– Home medical equipment, prosthetics/orthotics	20%	40%

\* Benefits marked with an asterisk (\*) are NOT subject to the calendar-year medical deductible.

<sup>#</sup> Copayments for services that are marked with a # do NOT count toward the copayment maximum and continue to be charged after it is reached. Deductible does not apply toward the Calendar Year Maximum

## COVERED SERVICES

## MEMBER COPAYMENT

### MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>7</sup>

	MHSA Participating Providers <sup>3</sup>	MHSA Non-Participating Providers <sup>3</sup>
– Inpatient services	\$100 per admission +20%	40% <sup>6</sup>
– Outpatient visits for severe mental health conditions	\$25/visit*	40%#*
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits) <sup>11</sup>	\$25/visit#	Not Covered

### CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup>

	See "Hospitalization Services"	
– Inpatient services for medical acute detoxification		
– Outpatient visits (up to 20 visits per calendar year combined with outpatient non-severe mental health visits) <sup>11</sup>	\$25/visit#	Not Covered

### HOME HEALTH SERVICES (combined maximum of 100 preauthorized visits per calendar year)

	Preferred Providers <sup>3</sup>	Non-Preferred Providers <sup>3</sup>
– Home Health and Home Infusion Care (See Prescription Drug Program for coverage of Home self-administered injectables)	20%	20% <sup>8</sup>

### HOSPICE<sup>9</sup>

– Routine Home Care and Inpatient Respite Care	No Charge	Not Covered
– 24-Hour Continuous Home Care and General Inpatient Care	20%	Not Covered

### OTHER

#### Alternative Care<sup>11</sup>

– Chiropractic services (up to 12 visits per calendar year)	\$25/visit	40%
– Acupuncture services <sup>10</sup> (up to 20 visits per calendar year)	\$25/visit	\$25/visit

#### Physical Medicine

– Office visits and related services (such as physical therapy and occupational therapy)	\$25/visit <sup>4</sup>	40%

#### Pregnancy and Maternity

– Prenatal and postnatal care	20% <sup>5</sup>	40%
– All necessary inpatient hospital services	See "Hospitalization Services"	

#### Family Planning

– Family planning counseling	\$25/visit* <sup>4</sup>	Not Covered
– Elective abortion, tubal ligation, vasectomy	20% <sup>5</sup>	Not Covered

#### Skilled Nursing Facility (SNF) Services (up to 100 days per calendar year)

– Semi-private accommodations – Freestanding SNF	20%	20%#
– Semi-private accommodations – Hospital SNF unit	20%	40% <sup>6</sup>

#### Diabetes Care

– Equipment, devices, and non-testing supplies (for testing supplies, please see "Prescription Drug Coverage")	20%	40%
– Self-management training and education	\$25/visit <sup>4</sup>	40%

#### Covered Out-of-State Benefits

20% or \$25 Copay 40%

Benefits offered through the BlueCard Program for out-of-state emergency and non-emergency care are provided at the Preferred Level of the local Blue Cross and Blue Shield Association Plan's Allowable Amount, when members use a Blue Cross and Blue Shield Association Plan provider.

<sup>1</sup> If the physician or member requests a brand name drug and a generic is available, the member is responsible for the difference in cost between the brand and the generic, in addition to the generic copayment.

<sup>2</sup> For retail prescriptions (for up to a 30-day supply) from a Non-Participating Pharmacy, the member pays 25% of the allowed charge in addition to the stated copayment. Mail-order prescriptions from a Non-Participating Pharmacy are not covered. Home self-administered injectable drugs from a participating retail pharmacy may require prior authorization from Blue Shield Pharmacy Services.

<sup>3</sup> Member is responsible for copayment in addition to any charges above the Allowable Amounts. The copayment percentage indicated is a percentage of allowed amounts. Preferred Providers accept Blue Shield's Allowable Amount as full payment for covered services. Non-Preferred Providers can charge more than these amounts. When members use Non-Preferred Providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's Allowable Amount. Charges in excess of the Allowable Amount do not count toward the calendar-year deductible or copayment maximum. Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA Participating Providers and MHSA Non-Participating Providers. Inpatient services for medical acute detoxification are accessed through Blue Shield using Blue Shield's Preferred and Non-Preferred Providers.

<sup>4</sup> There are Choice and Affiliated PPO providers. An additional \$10 member copayment per visit will apply for non-emergency professional services obtained from an Affiliated Provider.

<sup>5</sup> There are Choice and Affiliated PPO providers. An additional 10% member copayment will be charged when non-emergency professional or hospital facility services are obtained from an Affiliated Provider.

<sup>6</sup> The maximum allowed charges for non-emergency hospital services received from a Non-Preferred Hospital is \$600 per day. Members are responsible for 40% of this \$600 per day, plus all charges in excess of \$600. For Physician Services, members pay 40% of Allowable Amounts, plus all charges in excess of the Allowable Amounts.

<sup>7</sup> For a listing of Severe Mental Illnesses, including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the Evidence of Coverage or Plan Contract.

<sup>8</sup> Out-of-network home health care and home infusion services are not covered unless they are preauthorized by Blue Shield. When these services are preauthorized, members pay 20%, the Preferred Provider level.

<sup>9</sup> Covered Hospice Services received from any Hospice agency must be prior authorized by Blue Shield. If Blue Shield prior authorizes Hospice services from a Non-Participating Hospice Agency, those hospice services will be reimbursed at Participating Hospice Agency level.

<sup>10</sup> When members use acupuncture services, performed by a Preferred MD, they are responsible for the copayment. When services are obtained from a Non-Preferred MD or a certified acupuncturist, members are responsible for the copayment in addition to charges in excess of the allowed amount. <sup>11</sup>All acupuncture and chiropractic visits will now accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

<sup>11</sup> All outpatient non-severe mental health, outpatient substance abuse, acupuncture and chiropractic visits will now accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

*This chart only briefly describes the benefits of the \$250 Deductible 80/60 \$25 Copay PPO Plan. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Service Contract for the exact terms and conditions of coverage.*

*Benefits are subject to modification for subsequently enacted state or federal legislation.*

