

# SMALL GROUP HMO 100% Plan

All amounts listed are the member's responsibility to pay, unless otherwise noted.

CORE FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Annual Deductible</b>	None	None
<b>Lifetime Covered Charges Paid by Blue Cross</b>	Unlimited (in-network only, unless medical emergency)	Not applicable
<b>Annual Out-of-Pocket Maximum<sup>1</sup></b> Per family amount is aggregate, i.e., when one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members	<b>\$1,750</b> per member <b>\$3,500</b> per family (one or more members—aggregate) Certain member payments do not apply	Not applicable
<b>Office Visits</b> Includes office visits for maternity	<b>\$10</b> copay	Not covered
<b>Other Professional Services</b> Includes maternity, diagnostic lab and X-ray	No charge	Not covered
<b>Hospital Inpatient Facility Services</b> Preservice Review required	No charge	Not covered, except for emergency services
<b>Hospital Inpatient Professional Services</b> (lab, physician, anesthesia)	No charge	Not covered, except for emergency services
<b>Outpatient Facility Services</b> Preservice Review required for certain surgical services and diagnostic procedures	No charge	Not covered, except for emergency services
<b>Ambulatory Surgical Centers and Dialysis Centers</b> Preservice Review required	No charge	Not covered, except for emergency services
<b>Prescription Drugs<sup>2</sup></b> 30-day supply retail; up to a 60-day supply available through mail order	<u>Generic</u> : <b>\$10</b> copay  <u>Brand-name if generic not available</u> : <b>\$20</b> copay after <b>\$150</b> brand-name prescription drug deductible  <u>Brand-name if generic is available</u> : <b>\$10</b> copay <b>plus</b> the difference in cost between brand-name drug and generic equivalent after <b>\$150</b> brand-name prescription drug deductible  <u>Self-injectable (except insulin)</u> : <b>30%</b> of negotiated fee (subject to brand-name prescription drug deductible, if applicable)	<b>50%</b> of drug limited fee schedule plus <b>100%</b> of excess charges if filled within California after annual <b>\$150</b> brand-name prescription drug deductible per member, in-network and out-of-network combined  Mail order not available

<sup>1</sup> Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: copay paid or the brand-name prescription drug deductible applied under the pharmacy benefit; infertility copay; copay for not obtaining preservice review; non-covered services.

<sup>2</sup> Infertility Drugs: Infertility drug lifetime maximum Blue Cross payment \$1,500 in-network and out-of-network combined. All drugs: if a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name deductible.

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This is an overview of coverage. A comprehensive description of coverage, benefits and limitations is contained in the Combined Evidence of Coverage and Disclosure Form. Review the Exclusions and Limitations prior to applying for coverage.

ADDITIONAL FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Well Baby Immunizations and Adult Screening Tests</b>	\$10 copay per office visit	Not covered
<b>Emergency Care</b> • Professional Services • Facility Fees	No charge \$100 emergency room copayment – waived if admitted	No charge \$100 emergency room copayment – waived if admitted
<b>Ambulance</b>	No charge if ordered by the Primary Care Physician or in an emergency	Not covered, except for medical emergency services or authorized referral
<b>Skilled Nursing Facility</b> 100 days per year in a two-bed room Preservice Review required	No charge	Not covered
<b>Home Health Care</b> Up to 3 two-hour visits per day Preservice Review required	No charge if ordered by the Primary Care Physician	Not covered
<b>Physical/Occupational Therapy</b> Up to 60 consecutive days following an illness or injury	No charge if ordered by the Primary Care Physician	Not covered
<b>Chemical Dependency/Inpatient*</b> Detoxification for alcohol or drug abuse (acute stage only)	No charge	Not covered
<b>Mental Health/Outpatient Professional Services*</b> One visit per day, 20 visits per year	\$20 copay	Not covered
<b>Infusion Therapy/Chemotherapy</b> Preservice Review required	No charge	Not covered
<b>Infertility Services</b>	50% charge	Not covered

\* Except for coverage of severe mental illness and serious disturbances of a child.