

# SMALL GROUP Premier PPO \$20 Copay Plan

All amounts listed are the member's responsibility to pay after deductibles, unless otherwise noted. In-network negotiated fees can result in 30 to 40% savings compared to providers' usual fees.

CORE FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
<b>Annual Deductible</b> In-network and out-of-network combined, annual deductible applies towards annual out-of-pocket maximum	<b>\$250</b> per member for all medical services except office visits, annual Physical Exam, HealthyCheck screenings and prescription drugs; two-member maximum	
<b>Maximum Lifetime Covered Charges Paid by Blue Cross</b> In-network and out-of-network combined	\$5,000,000	
<b>Annual Out-of-Pocket Maximum</b> in-network and out-of-network maximums accumulate separately	<b>\$3,000</b> per member, two-member maximum; certain member payments do not apply <sup>1</sup>	<b>\$5,000</b> per member, two-member maximum
<b>Office Visits</b> Not subject to annual deductible	<b>\$20</b> copay for initial 12 office visits per member, additional office visits <b>40%</b> of negotiated fee	<b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges
<b>Other Professional Services</b> Includes maternity, diagnostic lab and X-ray	<b>20%</b> of negotiated fee after annual deductible	<b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges after annual deductible
<b>Hospital Inpatient Facility Services</b> Preservice Review required	<b>20%</b> of negotiated fee after annual deductible	<b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges after annual deductible
<b>Hospital Inpatient Professional Services</b> (lab, physician, anesthesia)	<b>20%</b> of negotiated fee after annual deductible	<b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges after annual deductible
<b>Outpatient Facility Services</b> Preservice Review required for certain surgical services and diagnostic procedures	<b>20%</b> of negotiated fee after annual deductible	<b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges after annual deductible
<b>Ambulatory Surgical Centers</b> Preservice Review required	<b>20%</b> of negotiated fee after annual deductible	All charges in excess of \$540 per day after annual deductible
<b>Prescription Drugs<sup>2</sup></b> 30-day supply retail; up to a 60-day supply available through mail order	Generic: <b>\$15</b> copay; brand-name: <b>\$25</b> copay; self-injectable (except insulin): <b>30%</b> of the negotiated fee	<b>40%</b> of drug limited fee schedule plus <b>100%</b> of excess charges if filled within California
<b>Annual Preventive Care Options (not subject to deductible):</b> each family member, ages 7-adult, may choose annually between physical exam or HealthyCheck screening.		
<b>Physical Exam</b> Maximum Blue Cross payment \$200 for members covered more than 6 months/\$100 if less; in-network and out-of-network combined	<b>\$20</b> copay for office visit plus <b>20%</b> of negotiated fee for all other covered services	<b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges
<b>OR</b>		
<b>HealthyCheck<sup>SM</sup> Screening</b> Includes certain lab tests, immunizations and health education information	<b>\$25</b> or <b>\$75</b> copay screening options	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 under the pharmacy benefit; copay paid for acupuncture/acupressure; copay for mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child), copay for not obtaining preservice review; HealthyCheck payments; \$500 copay for infertility services; 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 member selects a brand-name drug when a generic equivalent drug is available, and the physician does not write a "dispense as written" or "do not substitute" prescription, the member will be responsible for the brand-name copay plus the difference in cost between the brand-name drug and the generic equivalent drug.

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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 Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
<b>Well Baby Immunizations and Adult Screening Tests</b> <b>Children through age 6</b> Regular check-ups and immunizations <b>Ages 7-Adult</b> Includes annual Pap, breast exam, and mammogram for women, and Prostate Specific Antigen study for men	<b>\$20</b> office visit copay (not subject to deductible) plus <b>20%</b> of negotiated fee for all other covered services after annual deductible	<b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges after annual deductible
<b>Emergency Care</b> <b>\$100</b> Emergency Room copayment for each visit - waived if admitted	<b>20%</b> of negotiated fee after annual deductible	<b>20%</b> of customary and reasonable charges plus <b>100%</b> of excess charges for first 48 hours after annual deductible; after 48 hours <b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges after annual deductible
<b>Ambulance</b>	<b>20%</b> of negotiated fee after annual deductible	<b>40%</b> of customary and reasonable charges plus <b>100%</b> of excess charges after annual deductible
<b>Skilled Nursing Facility</b> 100 days per year, in-network and out-of-network combined; Preservice Review required	<b>20%</b> of negotiated fee after annual deductible	All charges in excess of \$150 per day after annual deductible
<b>Home Health Care</b> 100 four-hour visits per year, in-network and out-of-network combined; Preservice Review required	<b>20%</b> of negotiated fee after annual deductible	All charges in excess of \$75 per visit after annual deductible
<b>Physical/Occupational Therapy, Chiropractic Care</b> 12 visits per year, in-network and out-of-network combined	<b>20%</b> of negotiated fee after annual deductible	All charges in excess of \$25 per visit after annual deductible
<b>Acupuncture/Acupressure</b> 24 visits per year, in-network and out-of-network combined	<b>20%</b> of negotiated fee after annual deductible	All charges in excess of \$25 per visit after annual deductible
<b>Mental Health/Inpatient*</b> Includes chemical dependency 30 days per year, in-network and out-of-network combined; Preservice Review required	All of negotiated fee in excess of \$175 per day after annual deductible	All charges in excess of \$175 per day after annual deductible
<b>Mental Health/Outpatient Professional Services*</b> Includes chemical dependency One visit per day, 20 visits per year, in-network and out-of-network combined	All of negotiated fee in excess of \$25 per visit after annual deductible	All charges in excess of \$25 per visit after annual deductible
<b>Infusion Therapy</b> Includes chemotherapy Preservice Review required	<b>20%</b> of negotiated fee after annual deductible	All charges in excess of \$50 per day for all infusion therapy expenses except drugs; all charges in excess of the average wholesale price for all infusion therapy drugs; all charges in excess of the combined maximum Blue Cross payment of \$500 per day; after annual deductible
<b>Infertility Services</b> Maximum lifetime Blue Cross payment \$2,000, in-network and out-of-network combined	<b>\$500</b> copay plus <b>20%</b> of the balance of negotiated fee after annual deductible	<b>\$500</b> copay plus <b>40%</b> of the balance of customary and reasonable charges plus <b>100%</b> of excess charges after annual deductible

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