

SMALL GROUP PPO \$35 Copay GenRx 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
Annual Deductible In-network and out-of-network combined, annual deductible applies towards annual out-of-pocket maximum	\$500 for all medical services except office visits, HealthyCheck screenings and prescription drugs; two-member maximum	
Maximum Lifetime Covered Charges Paid by Blue Cross In-network and out-of-network combined	\$5,000,000	
Annual Out-of-Pocket Maximum	\$4,000 per member, two-member maximum Certain member payments do not apply ¹	Once Blue Cross payments reach \$10,000 per member, member pays nothing for covered expenses for the remainder of the year except charges over the allowed amounts ¹
Office Visits Not subject to annual deductible	\$35 copay for the first 12 visits per member, additional office visits 45% of negotiated fee	50% of negotiated fee plus 100% of excess charges
Other Professional Services Includes maternity, diagnostic lab and X-ray	35% of negotiated fee after annual deductible	50% of negotiated fee plus 100% of excess charges after annual deductible
Hospital Inpatient Facility Services Preservice Review required	35% of negotiated fee after annual deductible	All charges in excess of \$650 per day after annual deductible
Hospital Inpatient Professional Services (lab, physician, anesthesia)	35% of negotiated fee after annual deductible	50% of negotiated fee plus 100% of excess charges after annual deductible
Outpatient Facility Services Preservice Review required for certain surgical services and diagnostic procedures	35% of negotiated fee after annual deductible	All charges in excess of \$380 per day after annual deductible
Ambulatory Surgical Centers Preservice Review required	35% of negotiated fee after annual deductible	All charges in excess of \$380 per day after annual deductible
Prescription Drugs Coverage only for generic drugs listed on the Drug Formulary; brand-name drugs are not covered, but may be purchased at Blue Cross-negotiated savings from in-network pharmacies by presenting Blue Cross membership card Infertility drug lifetime maximum Blue Cross payment \$1500 in-network and out-of-network combined Amounts shown are copays for 30-day supply retail; up to a 60-day supply available by mail order	<u>Generic</u> : \$15 copay <u>Brand-name</u> : not covered <u>Generic self-injectable (except insulin)</u> : 30% of negotiated fee	50% of drug limited fee schedule plus 100% of excess charges if filled within California for generic drugs listed on the Drug Formulary
HealthyCheckSM Screenings, Ages 7-Adult Includes certain lab tests, immunizations and health education information	Not subject to annual deductible \$25 or \$75 copay health screening options	Not available

¹ Amounts 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) whether performed by a participating or non-participating provider; copay for not obtaining preservice review; \$500 copay for infertility services; non-covered services and copay made to non-participating providers.

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

ADDITIONAL FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
Well Baby Immunizations and Adult Screening Tests Children through age 6 Regular check-up and immunizations Ages 7-Adult Includes annual Pap, breast exam and mammogram for women and Prostate Specific Antigen study for men	\$35 copay for office visit; 35% of negotiated fee for all other covered services	50% of negotiated fee plus 100% of excess charges after annual deductible
Emergency Care \$100 Emergency Room copayment for each visit – waived if admitted	35% of negotiated fee after annual deductible	35% of customary and reasonable charges plus 100% of excess charges for first 48 hours after annual deductible; after 48 hours, all charges in excess of \$650 per day after annual deductible
Ambulance	35% of negotiated fee after annual deductible	50% of negotiated fee plus 100% of excess charges after annual deductible
Skilled Nursing Facility 100 days per year, in-network and out-of-network combined; Preservice Review required	35% of negotiated fee after annual deductible	All charges in excess of \$150 per day after annual deductible
Home Health Care 100 four-hour visits per year in-network and out-of-network combined; Preservice Review required	35% of negotiated fee after annual deductible	All charges in excess of \$75 per visit after annual deductible
Physical/Occupational Therapy, Chiropractic Care 12 visits per year, in-network and out-of-network combined	35% of negotiated fee after annual deductible	All charges in excess of \$25 per visit after annual deductible
Acupuncture/Acupressure 24 visits per year, in-network and out-of-network combined	All of the negotiated fee in excess of \$25 per visit after annual deductible	All charges in excess of \$25 per visit after annual deductible
Mental Health/Inpatient² Includes chemical dependency 30 days per year, in-network and out-of-network combined; Preservice Review required	All of the negotiated fee in excess of \$175 per day after annual deductible	All charges in excess of \$175 per day after annual deductible
Mental Health/Outpatient professional services² Includes chemical dependency One visit per day, 20 visits per year, in-network and out-of-network combined	All of the negotiated fee in excess of \$25 per visit after annual deductible	All charges in excess of \$25 per visit after annual deductible
Infusion Therapy Includes chemotherapy Preservice Review required	35% 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
Infertility Services Maximum lifetime Blue Cross payment \$2,000, in-network and out-of-network combined	\$500 copay plus 35% of the balance of negotiated fee after annual deductible	\$500 copay plus 50% of the balance of negotiated fee plus 100% of excess charges after annual deductible

² Except for coverage of severe mental illness and serious emotional disturbances of a child.