Effective Date: 1/1/15

Health Benefit Plan Summary

This Benefit Summary provides only a highlight of the services covered by

	PPO (Base Plan)	PPO (Buy-Up Plan)
Plan Type	A Preferred Provider Organization (PPO)	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at _____ to receive a complete listing of network hospitals and physicians)*	Members can receive services from any hospital or physician but receive greater benefits when they use the Blue-Card PPO network.	
Deductible	$1,000 per individual/$3,000 per family	$500 per individual/$1,500 per family
Coinsurance *(1)*	Network: 80%; Non-network: 60%	
Out-of-Pocket Maximum *(2)*	Network: $4,500 individual/$11,250 family; Non-network: $13,500 individual/$33,750 family	Network: $3,750 individual/$9,375 family; Non-network: $11,250 individual/$28,125 family
Physician Office Visits	Network: $30 copay *(3)* Non-network: Deductible then coinsurance	Network: $25 copay *(3)* Non-network: Deductible then coinsurance
Lab Performed in Physician's Office/Independent Lab	Network: Included in office visit copay Non-network: Deductible then coinsurance	
Lab Performed in Hospital/Outpatient Facility	Network: Deductible then coinsurance Non-network: Deductible then coinsurance	
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance *(4)* Non-network: Deductible then coinsurance	
Routine Preventive Care *(Contract lists covered services)*	Routine Services: 100% (not subject to deductible) Related OV: 100% Non-network: Deductible then coinsurance Unlimited calendar year maximum	Routine Services: 100% (not subject to deductible) Related OV: 100% Non-network: Deductible then coinsurance Unlimited calendar year maximum
Mammograms, Pap Smears and PSA tests	Network: 100% Non-network: Deductible then coinsurance	Network: 100% Non-network: Deductible then coinsurance
Routine Hearing Care	Newborn Hearing Screening Only – Deductible then coinsurance	
Childhood Immunizations	100%	
Inpatient Hospital Services/Outpatient Surgery**	Deductible then coinsurance *(4)*	
Emergency Room *(Copay waived if admitted to a hospital)*	$100 copay then Deductible then 80%	
Urgent Care	Network: $30 copay (office visit and lab only) *(5)* Non-network: Deductible then coinsurance	Network: $25 copay (office visit and lab only) *(5)* Non-network: Deductible then coinsurance
Ambulance	Deductible then 80%	
Durable Medical Equipment**	Deductible then coinsurance	
Allergy Testing, Treatment, Injections	Deductible then coinsurance	
Home Health Services**	Deductible then coinsurance 60 visit calendar year maximum	
Skilled Nursing Facility**	Deductible then coinsurance 30 day calendar year maximum	
Outpatient Therapy (Speech, Hearing, Physical, Occupational and Skeletal Manipulations)**	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 40 year calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	

[1] Portion of covered charges paid by after you satisfy your deductible and required copayments.
[2] Total of deductible, coinsurance and copays members pay each year toward covered charges before pays 100% of benefits.
[3] Other services/procedures not specified on this benefit schedule that are performed in a physician's office are subject to the Network Deductible and Coinsurance level.
[4] Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a $200 per visit/service. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical center) inside our service area are limited to a $200 per visit/service.
[5] Other services/procedures performed by an urgent care provider are subject to the Network Deductible and Coinsurance level.

	PPO (Base Plan)	PPO (Buy-Up Plan)
Inpatient Mental Illness/Substance Abuse	Deductible then coinsurance *Prior authorization required from New Directions*	
Outpatient Mental Illness/Substance Abuse	Network: Office Visit: $30 copay*(3)* Therapy: Deductible then coinsurance Non-Network: Deductible the coinsurance	Network: Office Visit: $25 copay*(3)* Therapy: Deductible then coinsurance Non-Network: Deductible the coinsurance
Organ Transplant**	Deductible then coinsurance Unlimited Lifetime Maximum	
Inpatient Hospice Facility**	Deductible then coinsurance 14 day lifetime maximum	
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-network: Deductible then 60%	
Prescription Drugs**	**Rx Network** $10 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $50 copay for Tier 2 brand drug; $70 copay for Tier 3 brand drug	
Prescription Drugs: **Mail order drug program – 102 day supply**	$20 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $100 copay for Tier 2 brand drug; $140 copay for Tier 3 brand drug	
Lifetime Maximum	Unlimited	
Notice	Your coverage does include elective pregnancy termination coverage. An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs. Please call Customer Service to exclude coverage.	
Dependent Coverage	End of the calendar year the children reach age 26 or the month they are no longer an eligible dependent, whichever is first.	
Prior Authorization Penalty **(Prior Authorization is required for selected services. See your certificate for a listing of services requiring Prior Authorization).**	You are responsible for prior authorization for services received. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.	
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.	
Detailed Benefit Information Exclusions and Limitations	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.	
Customer Service		

***Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, hi-tech scans, speech and hearing therapy (including home health for speech therapy), prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.*

The covered services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the contract.

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