

SMALL GROUP PPO 2400 (HSA-Compatible) 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 Medical/pharmacy combined; applies to Annual Out-of-Pocket Maximum	Single member: \$2,400 ; Family: \$4,800 aggregate	
Maximum Lifetime Covered Charges Paid by Blue Cross	\$5,000,000	
Annual Out-Of-Pocket Maximum Medical/pharmacy combined; certain member payments do not apply*	Single member: \$3,600 ; Family: \$5,500 aggregate	
Office Visits	\$35 copay after annual deductible	50% of negotiated fee plus 100% of excess charges after annual deductible
Other Professional Services Includes maternity, diagnostic lab and X-ray	20% 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	20% of negotiated fee after annual deductible	All charges in excess of \$650 per day after annual deductible
Hospital Inpatient Professional Services (lab, physician, anesthesia)	20% 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	20% of negotiated fee after annual deductible	All charges in excess of \$380 per day after annual deductible
Ambulatory Surgical Centers and Dialysis Centers Preservice Review required	20% of negotiated fee after annual deductible	All charges in excess of \$380 per day after annual deductible
Prescription Drugs² 30-day supply retail; up to a 60-day supply available through mail order; member payments apply to combined medical/pharmacy annual deductible	Generic: \$10 copay Brand-name: \$25 copay Self-injectable(except insulin): 30% of negotiated fee	50% of drug limited fee schedule plus 100% of excess charges if filled within California
Annual Preventive Care Options (not subject to deductible) each family member, ages 7-adult, may choose annually between a Physical Exam or a HealthyCheck screening		
Physical Exam: Maximum Blue Cross payment \$200 for members covered more than 6 months/\$100 if less; in-network and out-of-network combined.	\$35 for office visit charge; 20% of negotiated fee for related covered services; plus any negotiated fee amount in excess of the Blue Cross payment.	50% of negotiated fee for office visit charge; 50% of negotiated fee for related covered services; plus any amount in excess of the Blue Cross payment.
OR		
HealthyCheckSM Screening Includes certain lab tests, immunizations and health education information	\$25 or \$75 copay health screening options	Not available

¹ Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: copay paid for acupuncture/acupressure when performed by an out-of-network provider; copay paid for mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child) when performed by an out-of-network provider; \$500 copay for infertility services out-of-network; copay for not obtaining out-of-service preservice review; and non-covered services.

² 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 formulary 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 between the brand-name drug and the generic equivalent drug. For information about non-formulary drugs, please refer to the Certificate.

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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
<p>Well Baby Immunizations and Adult Screening Tests (deductible waived for office visit charge only)</p> <p>Children through age 6: regular check-ups and immunizations</p> <p>Ages 7-Adult: includes annual Pap, breast exam and mammogram for women and Prostate Specific Antigen study for men</p>	<p>\$35 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services after annual deductible</p>	<p>50% of negotiated fee plus 100% of excess charges</p>
<p>Emergency Care \$100 Emergency Room copayment for each visit - waived if admitted</p>	<p>20% of negotiated fee after annual deductible</p>	<p>20% of customary and reasonable charges plus 100% of excess charges after annual deductible</p>
<p>Ambulance</p>	<p>20% of negotiated fee after annual deductible</p>	<p>20% of customary and reasonable charges plus 100% of excess charges after annual deductible</p>
<p>Skilled Nursing Facility 100 days per year, in-network and out-of-network combined; Preservice Review required</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All charges in excess of \$150 per day after annual deductible</p>
<p>Home Health Care 100 four-hour visits per year, in-network and out-of-network combined; Preservice Review required</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All charges in excess of \$75 per visit after annual deductible</p>
<p>Physical/Occupational Therapy, Chiropractic Care 12 visits per year, in-network and out-of-network combined</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All charges in excess of \$25 per visit after annual deductible</p>
<p>Acupuncture/Acupressure 24 visits per year, in-network and out-of-network combined; in-network member payments apply to out-of-pocket maximum</p>	<p>All of the negotiated fee in excess of \$25 per visit after annual deductible</p>	<p>All charges in excess of \$25 per visit after annual deductible</p>
<p>Mental Health/Inpatient* Includes Chemical Dependency; 30 days per year, in-network and out-of-network combined; in-network member payments apply to out-of-pocket maximum Preservice Review required</p>	<p>All of the negotiated fee in excess of \$175 per day after annual deductible</p>	<p>All charges in excess of \$175 per day after annual deductible</p>
<p>Mental Health/Outpatient Professional Services* Includes Chemical Dependency; 1 visit per day, 20 visits per year, in-network and out-of-network combined; in-network member payments apply to out-of-pocket maximum</p>	<p>All of the negotiated fee in excess of \$25 per visit after annual deductible</p>	<p>All charges in excess of \$25 per visit after annual deductible</p>
<p>Infusion Therapy Includes Chemotherapy; Preservice Review required</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All charges in excess of \$50 per day (except for drugs); all charges in excess of average wholesale price for drugs; all charges in excess of combined maximum Blue Cross payment of \$500 per day; after annual deductible</p>
<p>Infertility Services Maximum lifetime Blue Cross payment \$2,000, in-network and out-of-network combined</p>	<p>\$500 copay plus 20% of the balance of negotiated fee after annual deductible</p>	<p>\$500 copay plus 50% of the balance of negotiated fee plus 100% of excess charges after annual deductible</p>

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