

# SMALL GROUP Advantage PPO \$25 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 screening 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>	<b>\$3,600</b> per member, two-member maximum (member pays <b>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600) Certain member payments do not apply <sup>1</sup>	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
<b>Office Visits</b> Not subject to annual deductible	<b>\$25</b> copay for initial 12 office visits per member, additional office visits <b>45%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600	<b>50%</b> of negotiated fee plus <b>100%</b> of excess charges
<b>Other Professional Services</b> Includes maternity, diagnostic lab and X-ray	<b>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, after annual deductible	<b>50%</b> of negotiated fee plus <b>100%</b> of excess charges after annual deductible
<b>Hospital Inpatient Facility Services</b> Preservice Review required	<b>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, after annual deductible	All charges in excess of \$650 per day after annual deductible
<b>Hospital Inpatient Professional Services</b> (lab, physician, anesthesia)	<b>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, after annual deductible	<b>50%</b> of negotiated fee 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>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, after annual deductible	All charges in excess of \$380 per day after annual deductible
<b>Ambulatory Surgical Centers</b> Preservice review required	<b>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, after annual deductible	All charges in excess of \$380 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	<u>Generic</u> : <b>\$15</b> copay; <u>brand-name if generic not available</u> : <b>\$25</b> copay; <u>brand-name if generic is available</u> : <b>\$15</b> copay <b>plus</b> the difference in cost between brand-name drug and generic equivalent; <u>self-injectable (except insulin)</u> : <b>30%</b> of negotiated fee	<b>50%</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 a physical exam or a 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>\$25</b> copay for office visit plus <b>30%</b> of negotiated up to \$900 and then <b>10%</b> from \$901 to \$3,600 for all other covered services	<b>50%</b> of negotiated fee, 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 health 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, 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.

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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
<b>Well Baby Immunizations and Adult Screening Tests Children through age 6</b> Regular check-up and immunizations <b>Ages 7-Adult</b> Includes annual Pap, breast exam, and mammogram for women, and Prostate Specific Antigen study for men	<b>\$25</b> office visit copay (not subject to deductible) <b>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600 for all other covered services, after annual deductible	<b>50%</b> of negotiated fee 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>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, after annual deductible	<b>30%</b> of customary and reasonable charges plus <b>100%</b> of excess charges for the first 48 hours after annual deductible; after 48 hours, all charges in excess of \$650 per day after annual deductible
<b>Ambulance</b>	<b>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, after annual deductible	<b>50%</b> of negotiated fee 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>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, 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>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, 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>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, 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	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
<b>Mental Health/Inpatient*</b> 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
<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 the 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>30%</b> of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600, after annual deductible	All charges in excess of \$50 per day for all 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>30%</b> of the balance of negotiated fee up to \$900 and then <b>10%</b> from \$901 to \$3,600 for all other covered services after annual deductible	<b>\$500</b> copay plus <b>50%</b> of the balance of negotiated fee plus <b>100%</b> of excess charges after annual deductible

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