

Summary of PPO Benefits



A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels.

ICUBA

Blue Choice PPO 70

Benefit	In-Network	Out-of-Network
Deductible		
Individual	\$750	\$1,250
Family	\$2,250	\$3,750
Coinsurance	70%	50%
Out-of-Pocket Maximums <i>(includes deductible, coinsurance and medical copays)</i>		
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000
Lifetime Maximum	No Maximum	
Physician Office Visits <i>(General Practice, Internal Medicine, Family Practice, Pediatrician, OB/GYN)</i>	100% after \$20 copayment	50% after deductible
Specialist Office Visits	100% after \$30 copayment	50% after deductible
Independent Clinical Labs (free standing facilities and office visits)	100% (not subject to deductible or co-payment)	50% after deductible
Preventive Care		
Annual Physical and Gynecological exam	100% (not subject to deductible or copayment)	Not Covered
Chlamydia and STD tests	100% (not subject to deductible or copayment)	Not Covered
PAP tests	100% (not subject to deductible or copayment)	Not Covered
Prostate cancer screenings (PSA)	100% (not subject to deductible or copayment)	Not Covered
Mammograms	100% (not subject to deductible or copayment)	Not Covered
Urinalysis	100% (not subject to deductible or copayment)	Not Covered
Venipuncture/Conveyance Fee	100% (not subject to deductible or copayment)	Not Covered
General Health Blood Panel, Glucose Test, Lipid Panel, Cholesterol, and ALT/AST.	100% (not subject to deductible or copayment)	Not Covered
Adult and Pediatric Immunizations	100% (not subject to deductible or copayment)	Not Covered
Related Wellness Services (e.g., blood stool tests, colonoscopies, sigmoidoscopies, electrocardiograms, echocardiograms and bone mineral density tests)	100% (not subject to deductible or copayment)	Not Covered
Allergy Injections	100% (not subject to deductible or copayment)	50% after deductible
Emergency Room Services	100% after \$100 copayment (waived if admitted)	
Ambulance	70% after in-network deductible	
Urgent Care Center	100% after \$30 copayment	

Benefit	In-Network	Out-of-Network
Hospital Expenses		
Inpatient	70% after \$250 per admission copayment (deductible applies)	50% after \$500 per admission copayment (deductible applies)
Outpatient	70% after deductible	50% after deductible
Outpatient Surgery		
Office Setting - Physician	100% after \$20 copayment	50% after deductible
Office Setting – Specialist	100% after \$30 copayment	50% after deductible
Outpatient Facility	70% after \$100 copayment (deductible applies)	50% after deductible
Related professional services	70% after deductible	50% after deductible
Infertility Services (Counseling and testing to diagnose)	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered	
Outpatient Physical Medicine	100% after \$30 copayment Limit: 30 visits/ benefit period	50% after deductible
Outpatient Speech Therapy (Restorative services only)	100% after \$30 copayment Limit: 30 visits/ benefit period	50% after deductible
Outpatient Occupation Therapy	100% after \$30 copayment Limit: 30 visits/ benefit period	50% after deductible
Spinal Manipulation	100% after \$30 copayment Limit: 60 visits/ benefit period	50% after deductible
Diagnostic Services (X-Ray and other tests)	70% after deductible	50% after deductible
Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET scan)	70% after \$100 per service copayment (deductible applies)	50% after deductible
Durable Medical Equipment	70% after deductible	50% after deductible
Prosthetic Appliances	70% after deductible	50% after deductible
Hearing Care Services		
Hearing aid screening/exam	100% after office visit copayment	
Hearing aid	70% after in-network deductible Combined limit: \$1,500/ benefit period	
Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment)	70% after deductible	50% after deductible
Inpatient Rehabilitation	70% after deductible \$250 Per-Admission co-pay also applies Limit: 60 days/ benefit period	50% after deductible \$500 Per-Admission co-pay also applies
Skilled Nursing Rehabilitation	70% after deductible Limit: 60 days/ benefit period	50% after deductible
Home Health Care	70% after deductible	50% after deductible
Private Duty Nursing	70% after deductible	50% after deductible
Hospice (Inpatient and Outpatient Care)	70% after deductible	50% after deductible
*Benefits available through MHNet: Mental Health, Substance Abuse and Employee Assistance Program call MHNet, available 24 hours at 877-398-5816 or visit www.mhnet.com .		
Mental Health*		
Inpatient	70% after \$250 per admission copayment (deductible applies)	50% after \$500 per admission copayment (deductible applies)
Outpatient	100% after \$20 copayment	50% after deductible
Substance Abuse*		
Inpatient Rehabilitation & Detoxification	70% after \$250 per admission copayment (deductible applies)	50% after \$500 per admission copayment (deductible applies)
Outpatient	100% after \$20 copayment	50% after deductible

Note on Out-of-Network Providers: Services rendered by an out-of-network provider may be subject to balance billing by the out-of-network provider for the difference between the allowed amount and provider billed charges.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program. Your benefit program maintains an appeal process involving three (3) levels of review with the exception of Urgent Care Claims (defined as Life threatening and subject to one level of review). Please see your Plan Document for detailed information on the appeals process.

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