

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 Options PPO 70

Benefit	In-Network	Out-of-Network
Deductible		
Individual	\$1,000	\$1,500
Family	\$2,500	\$4,000
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	

Benefit	In-Network	Out-of-Network
Urgent Care Center	100% after \$30 copayment	
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. Please see your Plan Document for detailed information on the appeals process.

Effective 4/1/12