Schedule of Benefits

Preferred Blue® PPO

Deductible

This is the *Schedule of Benefits* that is a part of your Subscriber Certificate. This chart describes the cost share amounts that you will have to pay for *covered services*. It also shows the *benefit limits* that apply for *covered services*. Do not rely on this chart alone. **Be sure to read all parts of your Subscriber Certificate to understand the requirements you must follow to receive all of your coverage. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for this coverage.** All words that show in italics are explained in Part 2. **To receive the highest level of coverage, you must obtain your health care services and supplies from *covered providers* who participate in your health plan's provider network.** Also, for some health care services, you may have to have an approved referral from your *primary care provider* or approval from your health plan in order for you to receive coverage from your health plan. These requirements are fully outlined in Part 4. If a referral or an approval is required, you should make sure that you have it before you receive your health care service. Otherwise, you may have to pay all costs for the health care service.

Your health plan's provider network is the **PPO** provider network. See Part 1 for information about how to find a provider in your health care network.

The following definitions will help you understand your cost share amounts and how they are calculated.

- A ***deductible*** is the cost you may have to pay for certain *covered services* you receive during your annual coverage period before benefits are paid by the health plan. This chart shows the dollar amount of your *deductible* and the *covered services* for which you must first pay the *deductible*.
- A ***copayment*** is the fixed dollar amount you may have to pay for a *covered service*, usually when you receive the *covered service*. This chart shows the times when you will have to pay a *copayment*.
- A ***coinsurance*** is the percentage (for example, 20%) you may have to pay for a *covered service*. This chart shows the times, if there are any, when you will have to pay *coinsurance*.

Your cost share will be calculated based on the *allowed charge* or the provider's actual charge if it is less than the *allowed charge*. You will not have to pay charges that are more than the *allowed charge* when you use a *covered provider* who participates in your health care network to furnish *covered services*. **But, when you use an out-of-network provider, you may also have to pay all charges that are in excess of the *allowed charge* for *covered services*. This is called "*balance billing*." These balance billed charges are in addition to the cost share you have to pay for *covered services*. (Exceptions to this paragraph are explained in Part 2.)**

IMPORTANT NOTE: The provisions described in this *Schedule of Benefits* may change. If this happens, the change is described in a *rider*. Be sure to read each *rider* (if there are any) that applies to your coverage in this health plan to see if it changes this *Schedule of Benefits*.

The explanation of any special provisions as noted by an asterisk can be found after this chart.

Overall Member Cost Share Provisions	In-Network Benefits	Out-of-Network Benefits
Deductible Your *deductible* per *plan year* is: This *deductible* applies to all *covered services* except in-network preventive health services, prescription drugs and supplies, and certain *covered services* as noted in this chart.	The *deductible* is the cost you have to pay for certain *covered services* during your annual coverage period before benefits will be paid for those *covered services*.	
	$1,000 per *member* $2,500 per family	
	The family *deductible* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member deductible*.	
Out-of-Pocket Maximum Your *out-of-pocket maximum* per *plan year* is: This *out-of-pocket maximum* is a total of the *deductible*, *copayments*, and *coinsurance* you pay for *covered services*.	The *out-of-pocket maximum* is the most you could pay during your annual coverage period for your share of the costs for *covered services*.	
	$5,450 per *member* $10,900 per family The amounts shown above exclude cost share you pay for your prescription drug benefits.	
	And a separate *out-of-pocket maximum* for prescription drug benefits: $1,000 per *member* $2,000 per family	
	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.	
Overall Benefit Maximum	None	

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Admissions for Inpatient Medical and Surgical Care	• In a General Hospital		
	Hospital services	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
	• In a Chronic Disease Hospital	(same as admissions in a General Hospital)	(same as admissions in a General Hospital)
	• In a Rehabilitation Hospital (60-day *benefit limit* per *member* per calendar year)		
	Hospital services	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit.*

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Admissions for Inpatient Medical and Surgical Care (continued)	• In a Skilled Nursing Facility (100-day *benefit limit* per *member* per calendar year)		
	Facility services	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	No charge after *deductible*	same as in-network benefits
	• Other ambulance	No charge after *deductible*	20% after *deductible*
Cardiac Rehabilitation	*Outpatient* services	$15 *copayment* per visit after *deductible*	20% after *deductible*
Chiropractor Services (for *members* of any age)	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services, including spinal manipulation (a *benefit limit* does not apply)	$15 *copayment* per visit after *deductible*	20% after *deductible*
Dialysis Services	*Outpatient* services and home dialysis	No charge after *deductible*	20% after *deductible*
Durable Medical Equipment	• Covered medical equipment rented or purchased for home use	20% after *deductible*	40% after *deductible*
	• One breast pump per birth (rented or purchased), including related parts and supplies	No charge (*deductible* does not apply)	20% after *deductible*
		No coverage is provided for hospital-grade breast pumps.	
Early Intervention Services	*Outpatient* intervention services for eligible child from birth through age two	No charge (*deductible* does not apply)	No charge (*deductible* does not apply)
Emergency Medical Outpatient Services	• Emergency room services	$150 *copayment* per visit after *deductible*; *copayment* waived if held for observation or admitted within 24 hours	same as in-network benefits
	• Hospital outpatient department services	$15 *copayment* per visit after *deductible*	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Emergency Medical Outpatient Services (continued)	• Office, health center, and home services		
	by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or multi-specialty provider group; or by a physician assistant or nurse practitioner designated by the health plan as primary care	$15 *copayment* per visit after *deductible*	20% after *deductible*
	by another specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	$15 *copayment* per visit after *deductible*	20% after *deductible*
Home Health Care	Home care program	No charge after *deductible*	20% after *deductible*
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	No charge after *deductible*	20% after *deductible*
Infertility Services	• *Inpatient* services	See Admissions for Inpatient Medical and Surgical Care	See Admissions for Inpatient Medical and Surgical Care
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• *Outpatient* lab tests		
	by a general hospital	No charge after *deductible*	20% after *deductible*
	by other *covered providers*	No charge after *deductible*	20% after *deductible*
	• *Outpatient* x-rays and other imaging tests (other than advanced imaging tests)		
	by a general hospital	No charge after *deductible*	20% after *deductible*
	by other *covered providers*	No charge after *deductible*	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit.*

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Lab Tests, X-Rays, and Other Tests (continued)	• *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)		
	by a general hospital	No charge after *deductible*	20% after *deductible*
	by other *covered providers*	No charge after *deductible*	20% after *deductible*
	• Other *outpatient* tests and preoperative tests		
	by a general hospital	No charge after *deductible*	20% after *deductible*
	by other *covered providers*	No charge after *deductible*	20% after *deductible*
Maternity Services and Well Newborn Care (includes $90/$45 for childbirth classes; *deductible* does not apply)	• Maternity services		
	Facility services (*inpatient* and *outpatient covered services*)	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services (includes delivery and postnatal care)	No charge after *deductible*	20% after *deductible*
	• Prenatal care	No charge (*deductible* does not apply)	20% after *deductible*
	• Well newborn care during covered maternity admission	No charge (*deductible* does not apply)	20% (*deductible* does not apply)
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	• Office, health center, and home medical services		
	by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, or multi-specialty provider group; or by a physician assistant or nurse practitioner designated by the health plan as primary care	$15 *copayment* per visit after *deductible*	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit.*

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Medical Care Outpatient Visits (continued)	• Office, health center, and home medical services by another specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	$15 *copayment* per visit after *deductible*	20% after *deductible*
	• Hospital outpatient medical services	$15 *copayment* per visit after *deductible*	20% after *deductible*
	• Acupuncture services (12-visit *benefit limit* per *member* per calendar year)	$15 *copayment* per visit after *deductible*	20% after *deductible*
Medical Formulas	Certain medical formulas and low protein foods	See Prescription Drugs and Supplies	See Prescription Drugs and Supplies
Mental Health and Substance Use Treatment	• *Inpatient* admissions in a General Hospital Hospital services	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
	• *Inpatient* admissions in a Mental Hospital or Substance Use Facility Facility services	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
	• *Outpatient* services	$15 *copayment* per visit after *deductible*	20% after *deductible*
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	No charge after *deductible*	20% after *deductible*
	• *Outpatient* respiratory therapy	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Podiatry Care	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Prescription Drugs and Supplies Drug Formulary (includes syringes and needles)	• Retail Pharmacy (30-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	 $15 *copayment* $30 *copayment* $50 *copayment*	 $30 *copayment* $60 *copayment* $100 *copayment*
		This cost share is waived for in-network Tier 1 birth control drugs and devices; certain in-network preventive drugs as required by federal law; insulin infusion pumps; and certain orally-administered anticancer drugs.	
	• Mail Order Pharmacy (90-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	 $30 *copayment* $60 *copayment* $150 *copayment*	 Not covered; you pay all charges
		This cost share is waived for Tier 1 birth control drugs and devices; certain preventive drugs as required by federal law; and certain orally-administered anticancer drugs.	
Preventive Health Services	• Routine pediatric care (ten visits first year of life, three visits second year of life, two visits age 2, and one visit per calendar year age 3 and older) <u>Routine medical exams and immunizations</u>	 No charge	 20% after *deductible*
	<u>Routine tests</u>	No charge	20% after *deductible*
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.	
	<u>Annual mental health wellness exams</u>	No charge	No charge (*deductible* does not apply)
	• Preventive dental care for *members* under age 18 for treatment of cleft lip/cleft palate	No charge	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit.*

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Preventive Health Services (continued)	• Routine adult care Routine medical exams and immunizations (one exam per *member* per calendar year)	No charge	20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; routine mammograms; blood tests to screen for lead poisoning; and routine colonoscopies.	
	Annual mental health wellness exams	No charge	No charge (*deductible* does not apply)
	• Routine GYN care Routine GYN exams (one exam per *member* per calendar year)	No charge	20% after *deductible*
	Routine Pap smear tests (one test per *member* per calendar year)	No charge	20% after *deductible*
	• Family planning	No charge	20% after *deductible*
	• Routine hearing care Routine hearing exams/tests	No charge	20% after *deductible*
	Newborn hearing screening tests	No charge	20% after *deductible*
	Hearing aids/related services for *members* age 21 or younger ($2,000 for one hearing aid per hearing-impaired ear every 36 months)	No charge	20% after *deductible*
	• Routine vision care Routine vision exams (one exam per *member* every 24 months)	No charge	20% after *deductible*
	Vision supplies/related services	Not covered; you pay all charges	Not covered; you pay all charges
Prosthetic Devices	• Ostomy supplies	No charge after *deductible*	20% after *deductible*
	• Artificial limb devices (includes repairs) and other external prosthetic devices	20% after *deductible*	40% after *deductible*
Radiation Therapy and Chemotherapy	*Outpatient* services	No charge after *deductible*	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit.*

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Second Opinions	*Outpatient* second and third opinions	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy) Includes habilitation services	*Outpatient* services (60-visit *benefit limit* per *member* per calendar year for physical and occupational therapy, except for autism; a *benefit limit* does not apply for speech therapy)	$15 *copayment* per visit after *deductible*	20% after *deductible*
Speech, Hearing, and Language Disorder Treatment	• *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* speech therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Surgery as an Outpatient (excludes removal of impacted teeth whether or not the teeth are imbedded in the bone)	• *Outpatient* day surgery Hospital surgical day care unit or outpatient department services	No charge after *deductible*	20% after *deductible*
	Ambulatory surgical facility services	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
	• Sterilization procedure for a female *member* when performed as the primary procedure for family planning reasons	No charge (*deductible* does not apply)	20% after *deductible*
	• Office and health center surgical services by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or multi-specialty provider group; or by a physician assistant or nurse practitioner designated by the health plan as primary care	$15 *copayment* per visit after *deductible*	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Surgery as an Outpatient (continued)	• Office and health center surgical services by another specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	$15 *copayment* per visit after *deductible*	20% after *deductible*
TMJ Disorder Treatment	• *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* physical therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit.*