

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 Risk Reward

| Benefit | In-Network | Out-of-Network |
|---|--|----------------------|
| Deductible | | |
| Individual | \$1,500 | \$3,000 |
| Family | \$4,500 | \$9,000 |
| Coinsurance | 80% | 60% |
| Out-of-Pocket Maximums (includes deductible) | | |
| Individual | \$3,500 | \$7,000 |
| Family | \$7,000 | \$14,000 |
| Lifetime Maximum | \$2,000,000 | |
| Physician Office Visits (General Practice, Internal Medicine, Family Practice, Pediatrician) | 80% (not subject to deductible) | 60% after deductible |
| Specialist Office Visits | 80% (not subject to deductible) | 60% after deductible |
| Independent Clinical Labs (free standing facilities and office visits) | 100% (not subject to deductible or co-payment) | 60% after deductible |
| Preventive Care | | |
| Annual Physical and Gynecological exam | 80% (not subject to deductible) | Not Covered |
| Chlamydia and STD tests | 100% (not subject to deductible or copayment) | Not Covered |
| PAP tests | 100% (not subject to deductible) | Not Covered |
| Prostate cancer screenings (PSA) | 100% (not subject to deductible) | Not Covered |
| Mammograms | 100% (not subject to deductible) | Not Covered |
| Urinalysis | 100% (not subject to deductible) | 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) | Not Covered |
| Adult and Pediatric Immunizations | 100% (not subject to deductible) | Not Covered |
| Related Wellness Services (e.g., blood stool tests, colonoscopies, sigmoidoscopies, electrocardiograms, echocardiograms and bone mineral density tests) | 100% (not subject to deductible) | Not Covered |
| Allergy Injections | 100% (not subject to deductible) | 60% after deductible |
| Emergency Room Services | 100% after \$100 copayment (waived if admitted) | |
| Ambulance | 80% after in-network deductible | |
| Urgent Care Center | 80%, not subject to deductible | |

| Benefit | In-Network | Out-of-Network |
|---|--|-----------------------|
| Hospital Expenses | | |
| Inpatient | 80% after deductible | 60% after deductible |
| Outpatient | 80% after deductible | 60% after deductible |
| Outpatient Surgery | | |
| Office Setting (Physician or Specialist) | 80% (not subject to deductible) | 60% after deductible |
| Outpatient Facility | 80% after deductible | 60% after deductible |
| Related professional services | 80% after deductible | 60% after deductible |
| Infertility Services (Counseling and testing to diagnose) | 80% after deductible | 60% after deductible |
| Assisted Fertilization Procedures | Not Covered | |
| Outpatient Physical Medicine | 80% (not subject to deductible) Limit: 30 visits/ benefit period | 60% after deductible |
| Outpatient Speech Therapy (Restorative services only) | 80% (not subject to deductible) Limit: 30 visits/ benefit period | 60% after deductible |
| Outpatient Occupation Therapy | 80% (not subject to deductible) Limit: 30 visits/ benefit period | 60% after deductible |
| Spinal Manipulation | 80% (not subject to deductible) Limit: 60 visits/ benefit period | 60% after deductible |
| Diagnostic Services (X-Ray and other tests) | 80% after deductible | 60% after deductible |
| Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET scan) | 80% after deductible | 60% after deductible |
| Durable Medical Equipment | 80% after deductible Limit: \$3,500/ benefit period | 60% after deductible |
| Prosthetic Appliances | 80% after deductible | 60% after deductible |
| Hearing Care Services | | |
| Hearing aid screening/exam | 80% (not subject to deductible) | |
| Hearing Aid | 80% after in-network deductible Combined limit: \$1,500/ benefit period | |
| Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment) | 80% after deductible | 60% after deductible |
| Inpatient Rehabilitation | 80% after deductible Limit: 60 days/ benefit period | 60% after deductible |
| Skilled Nursing Facility | 80% after deductible Limit: 60 days/ benefit period | 60% after deductible |
| Home Health Care | 80% after deductible | 60% after deductible |
| Private Duty Nursing | 80% after deductible | 60% after deductible |
| Hospice (Inpatient and Outpatient Care) | 80% after deductible | 60% 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 | 80% after deductible | 60% after deductible |
| Outpatient | 80% (not subject to deductible) | 60% after deductible |
| Substance Abuse* | | |
| Inpatient Rehabilitation & Detoxification | 80% after deductible | 60% after deductible |
| Outpatient | 80% (not subject to deductible) | 60% 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.