

# 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 Risk Reward

Benefit	In-Network	Out-of-Network
<b>Deductible</b>		
Individual	\$1,500	\$3,000
Family	\$4,500	\$9,000
<b>Coinsurance</b>	80%	60%
<b>Out-of-Pocket Maximums</b> (includes deductible)		
Individual	\$3,500	\$7,000
Family	\$7,000	\$14,000
<b>Lifetime Maximum</b>	\$2,000,000	
<b>Physician Office Visits</b> (General Practice, Internal Medicine, Family Practice, Pediatrician)	80% (not subject to deductible)	60% after deductible
<b>Specialist Office Visits</b>	80% (not subject to deductible)	60% after deductible
<b>Independent Clinical Labs</b> (free standing facilities and office visits)	100% (not subject to deductible or co-payment)	60% after deductible
<b>Preventive Care</b>		
Annual Physical and Gynecological exam	80% (not subject to deductible)	Not Covered
Chlamydia and STD tests	100% (not subject to deductible)	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)	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
<b>Allergy Injections</b>	100% (not subject to deductible)	60% after deductible
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)	
<b>Ambulance</b>	80% after in-network deductible	
<b>Urgent Care Center</b>	80%, not subject to deductible	

<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Hospital Expenses</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
<b>Outpatient Surgery</b>		
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
<b>Infertility Services</b> (Counseling and testing to diagnose)	80% after deductible	60% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Outpatient Physical Medicine</b>	80% (not subject to deductible)	60% after deductible
	Limit: 30 visits/ benefit period	
<b>Outpatient Speech Therapy</b> (Restorative services only)	80% (not subject to deductible)	60% after deductible
	Limit: 30 visits/ benefit period	
<b>Outpatient Occupation Therapy</b>	80% (not subject to deductible)	60% after deductible
	Limit: 30 visits/ benefit period	
<b>Spinal Manipulation</b>	80% (not subject to deductible)	60% after deductible
	Limit: 60 visits/ benefit period	
<b>Diagnostic Services</b> (X-Ray and other tests)	80% after deductible	60% after deductible
<b>Outpatient Diagnostic Imaging</b> (MRI, MRA, CAT Scan, PET scan)	80% after deductible	60% after deductible
<b>Durable Medical Equipment</b>	80% after deductible	60% after deductible
	Limit: \$3,500/ benefit period	
<b>Prosthetic Appliances</b>	80% after deductible	60% after deductible
<b>Hearing Care Services</b>		
Hearing aid screening/exam	80% (not subject to deductible)	
Hearing aid	80% after in-network deductible	
	Combined limit: \$1,500/ benefit period	
<b>Temporomandibular Joint Disorder</b> (Medical necessity required; excludes appliances and orthodontic treatment)	80% after deductible	60% after deductible
<b>Inpatient Rehabilitation</b>	80% after deductible	60% after deductible
	Limit: 60 days/ benefit period	
<b>Skilled Nursing Rehabilitation</b>	80% after deductible	60% after deductible
	Limit: 60 days/ benefit period	
<b>Home Health Care</b>	80% after deductible	60% after deductible
<b>Private Duty Nursing</b>	80% after deductible	60% after deductible
<b>Hospice</b> (Inpatient and Outpatient Care)	80% after deductible	60% after deductible
<b>*Benefits available through MHNet:</b>		
Mental Health, Substance Abuse and Employee Assistance Program call MHNet, available 24 hours at 877-398-5816 or visit <a href="http://www.mhnet.com">www.mhnet.com</a> .		
<b>Mental Health*</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% (not subject to deductible)	60% after deductible
<b>Substance Abuse*</b>		
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.

*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 Claim (defined as Life threatening and subject to one level of review). Please see your Plan Document for detailed information on the appeals process.*

*Effective 4/1/10*