

CLAY COUNTY BOARD OF COUNTY COMMISSIONERS



BCBS BlueChoice PPO Plan 716 Benefits

Deductibles:

- | | |
|---------------------------------------|-------|
| • Individual Calendar Year Deductible | \$250 |
| • Family Calendar Year Deductible | \$500 |
| • Hospital Per Admission Deductible | |
| – PPO Hospitals | \$0 |
| – Non-PPO Hospitals | \$250 |

NOTE: The calendar year deductible is waived for Independent Clinical Laboratory services. The hospital per admission deductible and the emergency room per visit deductible are in addition to the Calendar Year Deductible.

Coinsurance Percentage Payable by BCBSF:

- | | |
|----------------------|-----|
| • PPO Providers | 80% |
| • Non-PPO Providers | 70% |
| ~ Ambulance Services | 80% |

Maximum Out of Pocket Coinsurance Responsibility Per Calendar Year:

- | | |
|--------------------------------|---------|
| • Individual Coinsurance Limit | \$2,000 |
| • Family Coinsurance Limit | \$4,000 |

NOTE: Maximum Out of Pocket Coinsurance Responsibility Limits do not include any deductibles, copayments, any benefit penalty reduction, non-covered charges or any charges in excess of the allowed amount.

Office Services

- | | |
|--------------------------------------------------------------------------------------------------|------------------------------------------|
| • PPO Family Physicians
(Family Practice, General Practice, Internal Medicine, or Pediatrics) | \$20 Copay |
| • Other PPO Providers | \$20 Copay |
| – Allergy Injections (All PPO Providers) | \$5 Copay |
| • Non-PPO Providers | Calendar Year Deductible and Coinsurance |

NOTE: Durable Medical Equipment, Prosthetics, and Orthotics are not subject to the Copayment requirement, but are subject to the Individual Calendar Year Deductible and Coinsurance responsibility.

Calendar Year Maximums Per Insured

- | | |
|---------------------------------------------------------------------------------------------------------|---------|
| • Mental Health Services: | |
| – Inpatient days/visits or combination of inpatient and
Partial Hospitalization days | 30 |
| – Outpatient visits | 20 |
| • Home Health Care | \$5,000 |
| • Skilled Nursing Facility Days | 60 |
| • Low Protein Food Products | \$2,500 |
| • Outpatient Cardiac, Occupational, Physical, Speech, and
Massage Therapies and Spinal Manipulations | \$5,000 |

BlueScript Retail Pharmacy Program

- | | |
|-----------------------------------|------------------|
| • Preferred Generic Drugs | \$ 10.00 |
| • Preferred Brand Drugs | \$ 25.00 |
| • Non-Preferred Drugs | \$ 40.00 |
| • Maximum Supply | One month |
| • Oral Contraceptives and Devices | Covered |

Mail Order Pharmacy Program

- | | |
|---------------------------|----------------|
| • Preferred Generic Drugs | \$ 10.00 |
| • Preferred Brand Drugs | \$ 25.00 |
| • Non-Preferred Drugs | \$ 40.00 |
| • Maximum Supply | 90 days |

- Oral Contraceptives and Devices Covered

Lifetime Maximums Per Insured

- Total \$5,000,000
- Substance Dependency Care and Treatment (inpatient, outpatient, or any combination) \$5,000
- Hospice Benefit \$10,000

Wellness Benefit (Adults) \$300 Annual Maximum

Covered services for an adult (age 17 and over) include an annual exam and related wellness services up to a calendar year maximum of \$300. These services are not subject to the Calendar Year Deductible, Coinsurance or Copay up to Max. Routine vision and hearing examinations are not covered.

Additional Benefits

Accident Care

Accident care services are not subject to the Calendar Year Deductible, but are subject to the applicable copay, coinsurance and other deductible provisions of the plan

Mammogram Screening Services

Covered at 100% of allowed amount

Maternity

Covered for all members

Transplant Services

Heart, heart-lung combination, liver, kidney, cornea and bone marrow transplants

Well Child Care

Birth to age 16, 18 visits; deductible waived

This is a summary of benefits and not a contract. All benefits are subject to the provisions, exclusions and limitations set forth in the master contract. This plan provides coverage for certain physician office services, without having to satisfy a calendar year deductible requirement, when obtained from a PPO physician. To verify a provider's specialty or participation status, the insured may contact the local BCBSF office, contact the provider's office, or review the most recent Provider Directory. It is the insured's sole responsibility to select and verify a provider's network participation status at the time services are rendered.