

# Your Summary of Benefits



## Alternate PPO

### WSWHE Counties Health Insurance Consortium Trust

Benefit	In-Network <sup>1</sup>	Out-of-Network <sup>2,3</sup>
Deductible	N/A	\$200/\$500
Coinsurance	N/A	20%
Coinsurance Stop Loss	N/A	\$5,000/\$12,500/ (\$1,000/\$2,500 out-of-pocket)
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month)	Dep to 26	
Covered Preventive Care <sup>4</sup>	Member Pays In-Network	Member Pays Out-of-Network
Covered Adult Preventive Care	\$0	Deductible and Coinsurance
Annual Physical Exam	\$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	\$0	Deductible and Coinsurance
Preventive Well-Woman Care	\$0	Deductible and Coinsurance
Home/Office/Outpatient Care <sup>12</sup>	Member Pays In-Network	Member Pays Out-of-Network
Home/Office Visits	\$30/\$50 copay	Deductible and Coinsurance
Emergency Room/Facility (initial visit per occurrence)	\$200 copayment (Waived if admitted within 24 hours)	\$200 copayment (Waived if admitted within 24 hours)
Surgery <sup>5</sup> , Presurgical Testing, Anesthesia	\$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	\$0	Deductible and Coinsurance
Routine Maternity Care	\$0	Deductible and Coinsurance
Laboratory Tests, X-rays	\$0	Deductible and Coinsurance
MRI/MRA <sup>6</sup> , CAT Scan <sup>7</sup> , PET <sup>7</sup> & Nuclear Cardiology <sup>7</sup>	\$0	Deductible and Coinsurance
Allergy Testing & Treatment	\$30/\$50 copay (Waived for treatment)	Deductible and Coinsurance
Chiropractic Care <sup>9</sup>	\$30/\$50 copay	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	\$0	Coinsurance (no deductible)
Home Infusion Therapy	\$0	Covered in-network only
Hospice Care (Up to 210 days per lifetime)	\$0	Covered in-network only
Physical Therapy <sup>5</sup> (Up to 90 visits per calendar year combined in home, office or outpatient facility)	\$30/\$50 copay	Covered in-network only
Other Short-Term Rehabilitative Therapies — Speech/Language <sup>5</sup> , Occupational <sup>5</sup> , Vision (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$30/\$50 copay	Covered in-network only

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Benefit	In-Network <sup>1</sup>	Out-of-Network <sup>2,3</sup>
Cardiac Rehabilitation	\$30/\$50 copay	Deductible and Coinsurance
Second Surgical Opinion	\$30/\$50 copay	Deductible and Coinsurance
Kidney Dialysis	\$0	Deductible and Coinsurance
<b>Inpatient Care<sup>5</sup></b>	<b>Member Pays In-Network</b>	<b>Member Pays Out-of-Network</b>
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	\$0	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	\$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	\$0	Deductible and Coinsurance
Skilled Nursing Facility (Up to 120 days per calendar year)	\$0	Covered in-network only
<b>Mental Health<sup>8</sup></b>	<b>Member Pays In-Network</b>	
Outpatient Visits in Office	\$30 copay	Deductible and Coinsurance
Outpatient Visits in Facility	\$0	Deductible and Coinsurance
Inpatient Care <sup>8</sup> (As many days as medically necessary; semiprivate room and board)	\$0	Deductible and Coinsurance
<b>Alcohol/Substance Abuse<sup>8</sup></b>	<b>Member Pays In-Network</b>	<b>Member Pays Out-of-Network</b>
Outpatient Visits in Office	\$30 copay	Deductible and Coinsurance
Outpatient Visits in Facility	\$0	Deductible and Coinsurance
Inpatient Detoxification (As many days as medically necessary; semiprivate room and board)	\$0	Deductible and Coinsurance
Inpatient Rehabilitation	\$0	Deductible and Coinsurance
<b>Other</b>	<b>Member Pays In-Network</b>	<b>Member Pays Out-of-Network</b>
Medical Supplies	\$0 when obtained through Empire's medical supplies vendor	In-network benefits apply
Durable Medical Equipment <sup>6</sup>	\$0	Covered in-network only
Prosthetics & Orthotics <sup>6</sup>	\$0	Covered in-network only
Ambulance (air ambulance)	\$0	In-network benefits apply
Prescription Drugs <sup>10</sup>		Covered in-network only
Retail Program – One copay required for up to a 30-day supply	\$0 Deductible per person per calendar year \$10 copay for Tier 1 \$25 copay for Tier 2 \$50 copay for Tier 3 Includes Contraceptives (Retail & Mail-Order)	
Mail-Order Program <sup>11</sup> – Only two copays required for a 90-day supply	\$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above.	
Routine Vision Care	\$5 copay for 1 exam every 24 months \$10 copay for frames \$0 copay for lenses \$10 copay for soft lenses \$35 non-plan frame allowance	\$30 exam allowance \$30 frame allowance *allowances are available for certain lenses

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- (1) Network provider delivers care.
- (2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (7) for Mental Health and Alcohol/Substance Abuse Services.
- (3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount.
- (4) The following benefits, if provided in-network for preventive care, are not subject to copayment; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and up to two annual obstetric and gynecological examinations.
- (5) You are responsible for obtaining precertification from Empire's Medical Management Program for these services provided in-area and out-of-area, in-network and out-of-network. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
- (6) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers. You are responsible for obtaining precertification from Empire's Medical Management Program for in-area and out-of-area out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
- (7) Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the co-payment for covered services. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.
- (8) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
- (9) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network deductible and coinsurance for covered services. Authorization is not required for out-of-network services or for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.
- (10) This prescription drug coverage meets the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.
- (11) To receive a 90-day supply of prescription drugs through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.
- (12) The following practitioners receive the lower (primary) copay for services provided in an office: Patient's PCP, obstetrics, gynecologists, certified nurse midwives, chiropractors, and physical, occupational, speech and vision therapists. The higher (specialist) copay will apply for all other specialists when a Copay is required, and for services received in an outpatient facility for physical and other speech, language, occupational, vision and cardiac therapy.

PPO

Prepared on 3/28/2012