



Benefits Summary

Permian Basin Employer Health Plan Business Cooperative Plan A - High (1000)

COVERED SERVICES	MEMBER RESPONSIBILITY
Aggregate Lifetime Maximum Benefit	\$1,000,000
Calendar Year Deductible	\$1,000 per Member
Out-of-Pocket Maximum	\$10,000 per Member
Outpatient Services	
Physician office visits including laboratory, radiology, medication, supplies and materials administered in the Physician's office. Additional Copayments apply for surgical procedures.	
♦ Primary Care Physician	\$25 per visit to the PCP*
♦ Specialist	\$55 per visit to the Specialist*
Laboratory Services	Less than \$1,000 - No Copay* - Greater than \$1,000 - 20% of the Allowable Amount*
Diagnostic Radiology Services (except for the following): ♦ MRI, CT, Ultrasound, Sonogram, Nuclear Medicine, PET	No Copay* \$125 per procedure
Surgical Procedures performed in the Physician's office	\$75 per procedure
Pre and Post-Natal Obstetrical Care	No Copay*
Rehabilitation, Speech, Occupational and Physical Therapy	\$25 per visit
Outpatient Surgery	\$300 per admission
Physician Home Visits	\$50 per visit
Allergy Services ♦ Office Visits including Testing ♦ Serum ♦ Injection Administration	\$25 per visit to the PCP*; \$55 per visit to the Specialist* 50% of the Allowable Amount 50% of the Allowable Amount per visit
Short-term Mental Health Services Limited to 20 visits per Calendar Year	\$55 per visit
Serious Mental Illness Health Services Limited to 60 visits per Calendar Year	\$55 per visit
Chemical Dependency Services Limited to 3 series of treatments per lifetime	\$55 per visit
Preventive Health Care Services	
Routine Physical Exams	\$25 per visit to the PCP*
Well-Baby and Well-Child Care	\$25 per visit to the PCP*
Routine Immunizations	No Copay*
Well-Women Examinations	\$25 per visit*
Screening Mammograms	No Copay*
Bone Mass Measurement	No Copay*
Examinations for Detection of Prostate Cancer	Included in the office visit Copay*
Routine Sight, Speech and Hearing Screenings for Children	No additional Copay required when performed during an office visit*
Screening for the Detection of Colorectal Cancer	No Copay*
Family Planning and Infertility Services	
Family Planning Counseling	25 per visit to the PCP*; \$55 per visit to the Specialist*

* No Deductible

Family Planning and Infertility Services (continued)	
Contraceptive Devices and Implants <ul style="list-style-type: none"> ◆ Diaphragm ◆ IUD ◆ Subdermal Contraceptive Implants & Removal 	20% of the Allowable Amount for all charges Applies to materials, procedures and services
Sterilization Performed at an Outpatient Surgical Facility	\$300 per admission
Sterilization Performed in the Physician's office	\$50 per procedure
Infertility Services	Not Covered
Inpatient Services	
Inpatient Admissions including: <ul style="list-style-type: none"> ◆ Chemical Dependency Treatment Center ◆ Psychiatric Hospital ◆ Rehabilitation Facility ◆ Skilled Nursing Facility Tier 1 Hospital - Contracted Hospitals within the Service Area Tier 2 Hospital - Contracted Hospitals outside the Service Area	<i>Chemical Dependency: Limited to 3 series of treatments per lifetime</i> <i>Short-Term Mental Illness: Limited to 15 Inpatient days per Calendar Year</i> <i>Serious Mental Illness: Limited to 45 Inpatient days per Calendar Year</i> <i>Skilled Nursing Facility: Limited to 100 days per Calendar Year</i> Tier 1 - \$200 per day per admission, Max per admission \$1,000 Tier 2 - 30% of the Allowable Amount After Deductible
Observation Unit Admissions	\$200 per admission
Other Health Care Services	
Home Health Services (except for Speech, OT & PT services)	\$60 per visit
Non-Emergent Ambulance Services	\$150 per trip
Prosthetics/Orthotics/Heart Implants (Pacemakers, Stents)	20% of the Allowable Amount per device
Durable Medical Equipment (DME) and Medical Supplies	30% of the Allowable Amount per piece of equipment or supply. DME is limited to \$4,000 per Calendar Year. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the \$4,000 maximum.
Insulin and Diabetic Medications (up to a 30-day supply) <ul style="list-style-type: none"> ◆ 1st Tier - Generic Drugs ◆ 2nd Tier - Selected List of Brand Name Drugs ◆ 3rd Tier - Other Brand Name Drugs not on 2nd Tier Mail Order (up to a 90-day supply) <ul style="list-style-type: none"> ◆ 1st Tier - Generic Drugs ◆ 2nd Tier - Selected List of Brand Name Drugs ◆ 3rd Tier - Other Brand Name Drugs not on 2nd Tier 	\$15 per prescription* \$35 per prescription* \$65 per prescription* \$45 per prescription* \$105 per prescription* \$195 per prescription*
Diabetic Supplies	30% of the Allowable Amount per item*
Diabetic Self-Management Education	\$25 per visit to the PCP*; \$55 per visit to the Specialist*
Hearing Aids	Coverage is limited to a maximum of \$500 per ear once every 36 months
Dialysis Services	30% of the Allowable Amount
Organ Transplant Services	30% of the Allowable Amount
Immunosuppressive Medications, Injectable Drugs, Medically Infused Medications and Supplies, High Technology Drugs, Radiation Therapy, Chemotherapy and Associated Agents	Lifetime Maximum Benefit- \$250,000++ This does NOT increase the Aggregate Lifetime Maximum Benefit ◆ When cost is \$500 or less: No copayment - Included in the office visit, outpatient surgery or inpatient hospital Copay. ◆ When cost is more than \$500 - 30% of the Allowable Amount ++ This Lifetime Maximum Benefit does not apply to the treatment of cancer if after the initial diagnosis the member receives all cancer treatment in the Covenant Health System. If a member receives any cancer related service outside the Covenant Health System, the \$250,000 Lifetime Maximum Benefit applies.
Hospice Services	No Copay
Pain Management Services	30% of the Allowable Amount
Emergency Services	
Emergency Room	\$125 per visit
Minor Emergency or Urgent Care Center	\$50 per visit
Ground Ambulance & Air Ambulance	\$150 per ambulance trip after Deductible \$1,000 Transfer to Tier 1 hospital, 30% of the Allowable Amount to Tier 2 hospital after Deductible

* No Deductible