

Permian Basin Employer Health Plan  
Business Cooperative  
Benefit Summary - **Plan B High(1000)**

	<b>PREFERRED PROVIDER (In-Network Benefits)</b>	<b>NON-PREFERRED PROVIDER (Out-of-Network Benefits)</b>
<b>Deductible per Calendar Year</b> (Does not apply toward Out-of-Pocket Maximum)	\$1,000 per Insured \$3,000 per Family	\$3,000 per Insured \$9,000 per Family
<b>Out-of-Pocket Maximum per Calendar Year</b>	\$3,000 per Insured \$10,000 per Family	\$10,000 per Insured \$25,000 per Family
<b>PREAUTHORIZATION PENALTY</b>	Failure to Preauthorize reduces benefits by 50% or \$500, whichever is less	
<b>Hospital Services</b>		
Inpatient Room & Board charges and other Inpatient charges	80% after Deductible	60% after Deductible
Outpatient Surgery Facility	80% after Deductible	60% after Deductible
Pre-admission testing	80% after Deductible	60% after Deductible
<b>Physician and Health Care Provider Services</b> (including Laboratory & Radiology performed during an office visit)		
Office Visits to Non-Specialist Includes services of an Internist, General Physician, Family Practitioner or Pediatrician for routine care as well as diagnosis and treatment of an illness or injury.	\$25 per visit	60% after Deductible
Specialist Office Visits	\$55 per visit	60% after Deductible
Physician Home Visits	80% after Deductible	60% after Deductible
Physician Hospital Visits	80% after Deductible	60% after Deductible
Allergy Office Visits, including testing Non-Specialist Specialist	\$25 per visit \$55 per visit	50% after Deductible
Allergy Serum and Supplies	70% after Deductible	50% after Deductible
Surgery (Inpatient or Outpatient)	80% after Deductible	60% after Deductible
Laboratory and Radiology Services	80% after Deductible	60% after Deductible
<b>Preventive Health Care Services</b>		
Annual Physicals	\$25 Copayment	60% after Deductible
Well Child Care	\$25 Copayment	60% after Deductible
Immunizations for Newborns (birth through 6 years of age)	Covered in full when an immunization is administered without an office visit	
Newborn Child Hearing Screenings (birth to 30 days old)	80% Deductible waived	60% Deductible waived
Screening Mammograms	Covered in full - Deductible waived	60% after Deductible
<b>Family Planning Services</b>		
Counseling Services	\$55 per visit	60% after Deductible
Sterilization in an Inpatient or Outpatient Surgical Facility	80% after Deductible	60% after Deductible
<b>Outpatient Rehabilitative Services</b>	80% after Deductible	60% after Deductible
<b>Spinal Manipulation Services</b>	80% after Deductible up to \$50 per visit	60% after Deductible up to \$50 per visit
	Limited to 10 visits per Calendar Year	
<b>Immunosuppressive Medications, Injectable Drugs, Medically Infused Medications and Supplies, and High Technology Drugs.</b>	70% after Deductible	50% after Deductible
<b>Radiation Therapy, Chemotherapy and Associated Agents.</b> Lifetime Maximum \$250,000++ This does NOT increase the Aggregate Lifetime Maximum Benefit.	++This Lifetime Maximum Benefit does not apply to the treatment of cancer if after the initial diagnosis the insured receives all cancer treatment in the Covenant Health System. If an insured receives any cancer related service outside the Covenant Health System, the \$250,000 Lifetime Maximum Benefit applies.	
<b>Pain Management Services</b>	70% after Deductible	50% after Deductible

	<b>PREFERRED PROVIDER (In-Network Benefits)</b>	<b>NON-PREFERRED PROVIDER (Out-of-Network Benefits)</b>
<b>Organ Transplant Services</b>		
Physician Office Visits	70% after Deductible	60% after Deductible
Inpatient Surgery	70% after Deductible	50% after Deductible
<b>Chemical Dependency Services</b>		
Office Visits	\$55 Copayment	60% after Deductible
Outpatient or Inpatient Treatment	80% after Deductible	60% after Deductible
	Limited to three separate series of treatments per lifetime	
<b>Acute / Non-Chronic Mental Health Services</b>		
Office Visits	\$55 Copayment	60% after Deductible
	Maximum of 20 visits per Calendar Year	
Inpatient Services	80% after Deductible	60% after Deductible
	Maximum of 15 days per Calendar Year	
<b>Serious Mental Illness</b>		
Office Visits	\$55 Copayment	60% after Deductible
	Maximum of 60 visits per Calendar Year	
Inpatient Services	80% after Deductible	60% after Deductible
	Maximum of 45 days per Calendar Year	
<b>Prosthetic / Orthotic Devices /Heart Implants (Pacemakers, Stents)</b>		
	80% after Deductible	60% after Deductible
<b>Durable Medical Equipment (DME) and Medical Supplies</b>		
	80% after Deductible	60% after Deductible
	Limited to \$4,000 per Calendar Year	
<b>Limited Accidental Dental Care and Medically Related Oral Surgeries</b>		
Office Visits	\$55 Copayment	60% after Deductible
Outpatient Surgery	80% after Deductible	60% after Deductible
Inpatient Services	80% after Deductible	60% after Deductible
<b>Home Health Care</b>		
Home Visits	80% after Deductible	60% after Deductible
	Maximum of 60 visits per Calendar Year	
Home Infusion Therapy	70% after Deductible	50% after Deductible
<b>Skilled Nursing Facility Services</b>		
	80% after Deductible	60% after Deductible
	Maximum of 60 days per Calendar Year	
<b>Hospice Services</b>		
	100% after Deductible	60% after Deductible
	Lifetime maximum amount - \$20,000	
<b>Diabetes Services</b>		
Physician Office Visits - Non Specialist	\$25 per visit	60% after Deductible
Physician Office Visits - Specialist	\$55 per visit	
Self-Management Education	80% after Deductible	60% after Deductible
Supplies and Equipment	80% after Deductible	60% after Deductible
Insulin and Diabetic Medications (up to a 30-day supply)		Paid at 70% of the actual charges, after they are first reduced by the sum of the applicable In-Network pharmacy Copayment and any required difference in the cost between a Brand Name medication and a Generic medication.
◆ 1 <sup>st</sup> Tier - Generic Drugs	\$15 per prescription	
◆ 2 <sup>nd</sup> Tier - Selected List of Brand Name Drugs	\$35 per prescription	
◆ 3 <sup>rd</sup> Tier - Other Brand Name Drugs not on 2nd Tier	\$65 per prescription	
Mail Order (up to a 90-day supply)		
◆ 1 <sup>st</sup> Tier - Generic Drugs	\$45 per prescription	
◆ 2 <sup>nd</sup> Tier - Selected List of Brand Name Drugs	\$105 per prescription	
◆ 3 <sup>rd</sup> Tier - Other Brand Name Drugs not on 2nd Tier	\$195 per prescription	
<b>Emergency Care Services</b>		
	80% Deductible waived	
<b>Emergency Ambulance Services</b>		
	80% after Deductible	60% after Deductible
<b>All Other Covered Services</b>		
	80% after Deductible	60% after Deductible

**AGGREGATE LIFETIME MAXIMUM - \$1,000,000**

This chart only summarizes covered benefits.

Please refer to the Certificate of Insurance for coverage details including exclusions and limitations.