

# Benefits Summary

## Permian Basin Employer Health Plan Business Cooperative Plan D

Covered Services	Member Responsibility
<b>Aggregate Lifetime Maximum Benefit</b>	<b>\$500,000</b>
<b>Calendar Year Deductible - All other services</b>	<b>\$30,000 per Member</b>
<b>Limited Inpatient Services</b>	
Inpatient Admissions including Psychiatric Facilities	Short-Term Mental Illness: Limited to 15 Inpatient days per Calendar Year Serious Mental Illness: Limited to 45 Inpatient days per Calendar Year
Tier 1 Hospital -- All Contracted Hospitals in the Service Area Tier 2 Hospital -- All Contracted Hospitals outside the Service Area	Tier 1: \$500 Copay per Admission - no Deductible Tier 2: 30% of the Allowable Amount - after Deductible
<b>Limited Physician Visits</b>	
Routine Physical Exams, including: <ul style="list-style-type: none"> <li>◆ Well-Baby and Well-Child Care</li> <li>◆ Routine Immunizations</li> <li>◆ Well-Woman Examinations</li> <li>◆ Routine Sight, Speech and Hearing Screenings for Children</li> </ul>	\$50 per visit to PCP - No Deductible* * Visits for these services are limited to three visits per member per Calendar Year with No Deductible * Visits for these services subject to Deductible after maximum number of visits have been met
<b>Other Inpatient Admissions</b>	
<ul style="list-style-type: none"> <li>◆ Rehabilitation Facility</li> <li>◆ Chemical Dependency Treatment Center</li> <li>◆ Skilled Nursing Facility</li> </ul>	<i>Chemical Dependency: Limited to three series of treatments per lifetime</i> Tier 1: \$500 Copay per Admission - no Deductible Tier 2: 30% of the Allowable Amount - after Deductible
<b>Outpatient Services</b>	
PCP office visits including laboratory, radiology, medications, supplies, and materials	\$50 per visit to the PCP after Deductible
Specialist office visits including laboratory, radiology, medications, supplies, and materials	\$75 per visit to the Specialist after Deductible
Surgical Procedures performed in the Physician's office	\$100 per procedure after Deductible
Laboratory Services	\$10 per procedure after Deductible
Diagnostic Radiology Services (except for the following): <ul style="list-style-type: none"> <li>◆ Radiological Imaging &gt; \$200</li> </ul>	\$20 per procedure after Deductible \$200 per procedure after Deductible
Pre and Post-Natal Obstetrical Care	\$20 after Deductible
Rehabilitation, Speech, Occupational and Physical Therapy	\$25 per visit after Deductible
Outpatient Surgery	\$1,000 per admission after Deductible
Observation Unit Admissions	\$500 per admission after Deductible
Physician Home Visits	\$75 per visit after Deductible
Allergy Services: <ul style="list-style-type: none"> <li>◆ Office Visits including Testing</li> <li>◆ Serum &amp; Injection</li> </ul>	\$75 per visit after Deductible 50% of the Allowable Amount after Deductible
Short-term Mental Illness Health Services	\$75 per visit after Deductible. Limited to 20 visits per Calendar Year
Chemical Dependency Services	\$75 per visit after Deductible. Limited to three series of treatment per lifetime

Covered Services	Member Responsibility
Serious Mental Illness Health Services	\$75 per visit after Deductible. Limited to 60 visits per Calendar Year
<b>Preventive Health Care Services</b>	
<ul style="list-style-type: none"> <li>◆ Screening Mammograms</li> <li>◆ Bone Mass Measurement</li> <li>◆ Screening for the Detection of Colorectal Cancer</li> <li>◆ Examinations for Detection of Prostate Cancer</li> </ul>	\$25 per visit after Deductible
<b>Family Planning and Infertility Services</b>	
Family Planning Counseling	\$25 per visit after Deductible
Sterilization Performed at an Outpatient Surgical Facility	\$150 per admission after Deductible
Contraceptive Devices and Implants <ul style="list-style-type: none"> <li>◆ Diaphragm</li> <li>◆ IUD</li> <li>◆ Subdermal Contraceptive Implants &amp; Removal</li> </ul>	20% of the Allowable Amount for all charges after Deductible Applies to materials, procedures and services
Sterilization Performed in the Physician's office	\$100 per procedure after Deductible
Infertility Services	Not Covered
<b>Diabetic Services</b>	
Insulin and Diabetic Medications (up to a 30-day supply) <ul style="list-style-type: none"> <li>◆ 1<sup>st</sup> Tier - Generic Drugs</li> <li>◆ 2<sup>nd</sup> Tier - Selected List of Brand Name Drugs</li> <li>◆ 3<sup>rd</sup> Tier - Other Brand Name Drugs not on 2<sup>nd</sup> Tier</li> </ul>	\$15 per prescription after Deductible \$35 per prescription after Deductible \$65 per prescription after Deductible
Mail Order (up to a 90-day supply) <ul style="list-style-type: none"> <li>◆ 1<sup>st</sup> Tier - Generic Drugs</li> <li>◆ 2<sup>nd</sup> Tier - Selected List of Brand Name Drugs</li> <li>◆ 3<sup>rd</sup> Tier - Other Brand Name Drugs not on 2<sup>nd</sup> Tier</li> </ul>	\$45 per prescription after Deductible \$105 per prescription after Deductible \$195 per prescription after Deductible
Diabetic Supplies	30% per item of the Allowable Amount after Deductible
Diabetic Self-Management Education	\$25 per visit to the PCP after Deductible \$75 per visit to the Specialist after Deductible
<b>Other Health Care Services</b>	
Home Health Services	\$40 per visit after Deductible
Prosthetics/Orthotics/Heart Implants (Pacemakers, Stents)	30% of the Allowable Amount per device after Deductible
Durable Medical Equipment (DME) and Medical Supplies	30% of the Allowable Amount per piece of equipment or supply after Deductible. 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
Hearing Aids	Coverage is limited to a maximum of \$500 per ear once every 36 months after Deductible
Dialysis Services	30% of the Allowable Amount after Deductible
Organ Transplant Services	30% of the Allowable Amount after Deductible
Radiation Therapy, Immunosuppressive Medications, Chemotherapy and Associated Agents, Injectable Drugs, Medically Infused Medications and Supplies, and High Technology Drugs.	30% of the Allowable Amount after Deductible <b>Lifetime Maximum Benefit \$30,000</b>
Hospice Services	\$20 per visit after Deductible
Pain Management Services	30% of the Allowable Amount after Deductible
Non-Emergent Ambulance Services	\$500 after Deductible
<b>Emergency Services</b>	
Emergency Room	\$500 after Deductible per Hospital emergency room visit. Emergency room Copay is waived if admitted to Hospital
Minor Emergency or Urgent Care Center	\$50 per visit after Deductible
Ambulance	\$500 per ambulance trip after Deductible
Air Ambulance	\$1,000 Transfer to Tier 1 hospital, 40% of the Allowable Amount to Tier 2 hospital after Deductible