

# Permian Basin Employer Health Plan Business Cooperative Benefit Summary - **Plan B Low(2500)**

	<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)	\$2,500 per Insured \$7,500 per Family	\$7,500 per Insured \$20,000 per Family
<b>Out-of-Pocket Maximum per Calendar Year</b>	\$5,000 per Insured \$12,500 per Family	\$15,000 per Insured \$30,000 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	70% after Deductible	50% after Deductible
Outpatient Surgery Facility	70% after Deductible	50% after Deductible
Pre-admission testing	70% after Deductible	50% after Deductible
<b>Physician and Health Care Provider Services</b> (including Laboratory & Radiology performed during an Office Visit)		
Office Visits to Non-Specialist <small>Includes services of an Internist, General Physician, Family Practitioner or Pediatricians for routine care as well as diagnosis and treatment of an illness or injury.</small>	\$25 per visit	50% after Deductible
Specialist Office Visits	\$60 per visit	50% after Deductible
Physician Home Visits	70% after Deductible	50% after Deductible
Physician Hospital Visits	70% after Deductible	50% after Deductible
Allergy Office Visits - including testing Non-Specialist Specialist	\$25 per visit \$60 per visit	50% after Deductible
Allergy Serum and Supplies	70% after Deductible	50% after Deductible
Surgery (Inpatient or Outpatient)	70% after Deductible	50% after Deductible
Laboratory and Radiology Services	70% after Deductible	50% after Deductible
<b>Preventive Health Care Services</b>		
Annual Physicals	\$25 Copayment	50% after Deductible
Well Child Care	\$25 Copayment	50% 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)	70% Deductible waived	50% Deductible waived
Screening Mammograms	Covered in full - Deductible waived	50% after Deductible
<b>Family Planning Services</b>		
Counseling Services	\$60 Copayment	50% after Deductible
Sterilization in an Inpatient or Outpatient Surgical Facility	70% after Deductible	50% after Deductible
<b>Outpatient Rehabilitative Services</b>	70% after Deductible	50% after Deductible
<b>Spinal Manipulation Services</b>	70% after Deductible up to \$50 per visit	50% after Deductible up to \$50 per visit
	Limited to 10 visits per Calendar Year	
<b>Second Surgical Opinion</b>	\$60 Copayment	50% after Deductible
<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>	++ 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 \$50,000 Lifetime Maximum Benefit applies.	
<b>Lifetime Maximum \$50,000++</b> This does NOT increase the Aggregate Lifetime Maximum Benefit.		
<b>Pain Management Services</b>	70% after Deductible	50% after Deductible

	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
<b>Organ Transplant Services</b>		
Physician Office Visits	70% after Deductible	50% after Deductible
Inpatient Surgery	70% after Deductible	50% after Deductible
<b>Chemical Dependency Services</b>		
Office Visits	\$60 Copayment	50% after Deductible
Outpatient or Inpatient Treatment	70% after Deductible	50% after Deductible
	Limited to three separate series of treatments per lifetime	
<b>Acute / Non-Chronic Mental Health Services</b>		
Office Visits	\$60 Copayment	50% after Deductible
	Maximum of 20 visits per Calendar Year	
Inpatient Services	70% after Deductible	50% after Deductible
	Maximum of 15 days per Calendar Year	
<b>Serious Mental Illness</b>		
Office Visits	\$60 Copayment	50% after Deductible
	Maximum of 60 visits per Calendar Year	
Inpatient Services	70% after Deductible	50% after Deductible
	Maximum of 45 days per Calendar Year	
<b>Prosthetic / Orthotic Devices / Heart Implants (Pacemakers, Stents)</b>		
	70% after Deductible	50% after Deductible
<b>Durable Medical Equipment (DME) and Medical Supplies</b>		
	70% after Deductible	50% after Deductible
	Limited to \$4,000 per Calendar Year	
<b>Limited Accidental Dental Care and Medically Related Oral Surgeries</b>		
Office Visits	\$60 Copayment	50% after Deductible
Outpatient Surgery	70% after Deductible	50% after Deductible
Inpatient Services	70% after Deductible	50% after Deductible
<b>Home Health Care</b>		
Home Visits	70% after Deductible	50% after Deductible
	Maximum of 60 visits per Calendar Year	
Home Infusion Therapy	70% after Deductible	50% after Deductible
<b>Skilled Nursing Facility Services</b>		
	70% after Deductible	50% after Deductible
	Maximum of 60 days per Calendar Year	
<b>Hospice Services</b>		
	100% after Deductible	50% after Deductible
	Lifetime maximum amount - \$20,000	
<b>Diabetes Services</b>		
Physician Office Visits - Non-Specialist	\$25 per visit	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.
Physician Office Visits - Specialist	\$60 per visit	
Self-Management Education	70% after Deductible	
Supplies and Equipment	70% after Deductible	
Insulin and Diabetic Medications (up to a 30-day supply)		
◆ 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>		
	70% Deductible waived	
<b>Emergency Ambulance Services</b>		
	70% Deductible waived	
<b>All Other Covered Services</b>		
	70% after Deductible	50% after Deductible

**AGGREGATE LIFETIME MAXIMUM - \$750,000**

This chart only summarizes covered benefits.

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