



# Hospital Benefits Plus Plan

AGENT REFERENCE ONLY

*The following information is provided as an informal reference for Blue Cross agents* to provide more detailed information about covered benefits under this plan compared to other Blue Cross Small Group plans. Members should be referred to the BeneFits brochure (form # 10527) for a sales communication and to the Certificate for a comprehensive description of coverage, benefits, special circumstances and limitations. Amounts listed are the member's responsibility pay unless otherwise noted.

|   | IN-NETWORK  | OUT-OF-NETWORK  |
|---|---|---|
| <b>Annual Deductible</b>  | \$1,000 per member, two-member max  |   |
| <b>Lifetime Covered Charges Paid by Blue Cross</b><br>In-network and out-of-network combined  | 5,000,000 Lifetime Max  |   |
| <b>Annual Out-of-Pocket Maximum</b><br>In-network and out-of-network combined. Certain payments do not apply (see Certificate for complete details)                                       | Deductible plus \$2,500 per member, two-member max  |   |
| <b>Office Visits</b><br><i>Includes lab and X-ray</i>   | 50% up to a maximum benefit of \$500 per calendar year per member.  |   |
| <b>Other Professional Services</b>  | 30% of negotiated fee after deductible  | 50% of the negotiated fee, plus 100% of charges in excess of the negotiated fee after deductible                  |
| <b>Inpatient Facility Services</b><br>Preservice Review required  | 30% of negotiated fee after deductible  | Member pays all charges except \$650 per day after the deductible   |
| <b>Inpatient Professional Services</b>  | 30% of negotiated fee after deductible  | 50% of the negotiated fee, plus 100% of charges in excess of the negotiated fee after deductible                  |
| <b>Outpatient Facility Services</b><br>Limited to surgery, medical emergency, radiation therapy, hemodialysis treatment and infusion therapy<br>Preservice required.                      | 30% of negotiated fee after deductible  | Member pays all charges except \$380 per day after the deductible   |
| <b>Prescription Drugs</b><br>30-day supply retail; up to a 60 day supply available through mail order   | No subject to deductible<br>\$15 copay for generic drugs (for each 30-day supply)<br>30% of negotiated fee for self-administered Injectable drugs, except insulin. (for each 30-day supply) | Not subject to deductible<br>50% of Drug limited Fee Schedule, plus 100% of charges in excess of drug limited fee |
| <b>HealthyCheck<sup>SM</sup> Ages 7-adult</b><br>Includes certain lab tests, immunizations and health education information   | Not subject to deductible<br>\$25 or \$75 copay health screening options <sup>0</sup>   | Not covered   |
| <b>Preventive Care</b><br><i>Well baby immunizations; ages 7-adult screening tests limited to annual Pap, breast exam and mammogram for women Prostate Specific Antigen (PSA) for men</i> | 30% of the negotiated fee after deductible  | 50% of the negotiated fee, plus 100% of charges in excess of the negotiated fee after deductible                  |
| <b>Annual Physical Exam</b>   | No Benefits   | No Benefits   |

**Hospital Benefits Plus Plan Agent Reference ... continued**

|  | <b>IN-NETWORK</b>   | <b>OUT-OF-NETWORK</b>   |
|--|---|---|
| <b>Emergency Care</b><br>\$100 copay for each visit – waived if admitted   | 30% of the negotiated fee after the deductible  | 30% of customary and reasonable charges, plus 100% of excess for first 48 hours; after 48 hours, all charges in excess of \$650 per day after deductible.   |
| <b>Ambulance</b><br>\$750 per trip maximum Blue Cross Payment  | 30% of the negotiated fee, plus 100% of charges in excess of \$750 per trip maximum up to the negotiated amount, after deductible       | 50% of the negotiated fee, plus 100% of charges in excess of \$750 per trip maximum up to the negotiated amount, after deductible   |
| <b>Skilled Nursing Facility</b><br>100 days per year, in-network and out-of-network combined<br>Preservice Review required                           | 30% of the negotiated fee, plus 100% of charges in excess of \$540 per day maximum up to the negotiated amount, after the deductible    | After the deductible is satisfied, all charges except \$150 per day   |
| <b>Home Health Care</b><br>100 four-hour visits per year, in-network and out-of-network combined<br>Preservice Review required                       | 30% of the negotiated fee, plus 100% of charges in excess of \$137.50 per day maximum up to the negotiated amount, after the deductible | After the deductible is satisfied, all charges except \$75 per day  |
| <b>Physical/Occupational Therapy, Chiropractic Care</b>  | No Benefits   | No Benefits   |
| <b>Acupuncture/Acupressure</b><br>12 visits per year, in-network and out-of-network combined   | All charges except \$25 per visit after deductible  | All charges except \$25 per visit after deductible  |
| <b>Mental Health *</b><br>Professional Services<br>Includes chemical dependency  | Not covered   | Not covered   |
| <b>Mental Health*</b><br>Facility Based Treatment (30 days per year maximum, in-network and out-of-network combined)<br>Includes chemical dependency | After the deductible is satisfied, all of the negotiated fee except \$175 per day.  | After the deductible is satisfied, all charges except \$175 per day.  |
| <b>Infusion Therapy</b><br>Includes chemotherapy<br>Preservice Review required.  | 30% of the negotiated fee after deductible  | 50% of the negotiated fee, plus 100% of charges in excess of \$50 per day for all infusion therapy expenses except drugs; all charges in excess of the average wholesale price for all infusion therapy drugs; all charges in excess of the combined maximum of \$500 Blue Cross payment per day after deductible.  |
| <b>Infertility Services</b><br>Lifetime maximum \$2,000, in-network and out-of-network combined  | 30% of the negotiated fee after deductible  | Inpatient facility services:<br>Member pays all charges except \$650 per day after deductible<br>Outpatient facility services:<br>Member pays all charges except \$380 per day after deductible<br>Professional services related to covered hospital charges. 50% of the negotiated fee, plus 100% of charges in excess of the negotiated fee after deductible. |

\*except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child. Benefits for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child are provided on the same basis as any other medical condition.