California Indian Tribe PPO $40 Copay Plan

All amounts listed are the member's responsibility to pay after deductibles, unless otherwise noted. In-network negotiated fees can result in 30 to 40% savings compared to providers' usual fees. Your entire tribe must be on the same plan.

This is an overview of coverage. A comprehensive description of coverage, benefits and limitations is contained in the Combined Evidence of Coverage and Disclosure Form that may be requested by calling (866) 255-4970.

CORE FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
Annual Deductible In-network and out-of-network combined, annual deductible applies towards annual out-of-pocket maximum	**$500** per member for all medical services except office visits, HealthyCheck screenings and prescription drugs; two-member maximum	
Maximum Lifetime Covered Charges Paid by Blue Cross In-network and out-of-network combined	$5,000,000	
Annual Out-of-Pocket Maximum	**$4,500** per member, two-member maximum Certain member payments do not apply[1]	Once Blue Cross payments reach $10,000 per member, member pays nothing for covered expenses for the remainder of the year except charges over the allowed amounts
Office Visits Not subject to annual deductible	**$40** copay for initial 12 office visits per member, additional office visits **45%** of negotiated fee	**50%** of negotiated fee, plus **100%** of excess charges
Other Professional Services Includes maternity, diagnostic lab and X-ray	**40%** of negotiated fee after annual deductible	**50%** of negotiated fee, plus **100%** of excess charges after annual deductible
Hospital Inpatient Facility Services Preservice Review required	**40%** of negotiated fee after annual deductible	All charges in excess of $650 per day after annual deductible
Hospital Inpatient Professional Services (lab, physician, anesthesia)	**40%** of negotiated fee after annual deductible	**50%** of negotiated fee, plus **100%** of excess charges after annual deductible
Outpatient Facility Services Preservice Review required for certain services and procedures	**40%** of negotiated fee after annual deductible	All charges in excess of $380 per day after annual deductible
Ambulatory Surgical Centers Preservice Review required	**40%** of negotiated fee after annual deductible	All charges in excess of $380 per day after annual deductible
Prescription Drugs[2] 30-day supply retail; up to a 60-day supply available through mail order	Generic: **$15** copay Brand-name if generic not available: **$25** copay after annual **$150** brand-name prescription drug deductible Brand-name if generic is available: **$15** copay after annual **$150** brand-name prescription drug deductible **plus** the difference in cost between brand-name drug and generic equivalent Self-injectable (except insulin): **30%** of negotiated fee (subject to brand-name prescription drug deductible if applicable)	**50%** of drug limited fee schedule plus **100%** of excess charges if filled within California after annual **$150** brand-name prescription drug deductible per member, in-network and out-of-network combined
HealthyCheck℠ Screenings, Ages 7- Adult Includes certain lab tests, immunizations and health education information	***Not subject to annual deductible*** **$25** or **$75** copay health screening options	Not available

[1] *Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: copay paid under the pharmacy benefit; copay paid for acupuncture/ acupressure; copay for mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child); copay for not obtaining preservice review; HealthyCheck payments; $500 copay for infertility services; non-covered services.*

[2] *Infertility Drugs: Infertility drug lifetime maximum Blue Cross payment $1,500 in-network and out-of-network combined. All drugs: if member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name deductible.*

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This is an overview of coverage. A comprehensive description of coverage, benefits and limitations is contained in the Combined Evidence of Coverage and Disclosure Form. Review the Exclusions and Limitations prior to applying for coverage.

ADDITIONAL FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
Well Baby Immunizations and Adult Screening Tests **Children through age 6** Regular check-up and immunizations **Ages 7-Adult** Includes annual Pap, breast exam, and mammogram for women and Prostate Specific Antigen study for men	**$40** copay for office visits (not subject to deductible); **40%** of negotiated fee for all other covered services after annual deductible	**50%** of negotiated fee, plus **100%** of excess charges after annual deductible
Emergency Care **$100** Emergency Room copayment for each visit – waived if admitted	**40%** of negotiated fee after annual deductible	**40%** of customary and reasonable charges plus **100%** of excess charges for first 48 hours after annual deductible; after 48 hours, all charges in excess of $650 per day after annual deductible
Ambulance	**40%** of negotiated fee after annual deductible	**50%** of negotiated fee plus **100%** of excess charges after annual deductible
Skilled Nursing Facility 100 days per year, in-network and out-of-network combined; Preservice Review required	**40%** of negotiated fee after annual deductible	All charges in excess of $150 per day after annual deductible
Home Health Care 100 four-hour visits per year, in-network and out-of-network combined; Preservice Review required	**40%** of negotiated fee after annual deductible	All charges in excess of $75 per visit after annual deductible
Physical/Occupational Therapy, Chiropractic Care 12 visits per year, in-network and out-of-network combined	**40%** of negotiated fee after annual deductible	All charges in excess of $25 per visit after annual deductible
Acupuncture/Acupressure 24 visits per year, in-network and out-of-network combined	All of the negotiated fee in excess of $25 per visit after annual deductible	All charges in excess of $25 per visit after annual deductible
Mental Health/Inpatient* Includes chemical dependency; 30 days per year, in-network and out-of-network combined; Preservice Review required	All of the negotiated fee in excess of $175 per day after annual deductible	All charges in excess of $175 per day after annual deductible
Mental Health/Outpatient Professional Services* Includes chemical dependency; One visit per day, 20 visits per year, in-network and out-of-network combined	All of the negotiated fee in excess of $25 per visit after annual deductible	All charges in excess of $25 per visit after annual deductible
Infusion Therapy Includes chemotherapy Preservice Review required	**40%** of negotiated fee after annual deductible	All 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 Blue Cross payment of $500 per day; after annual deductible
Infertility Services Maximum lifetime Blue Cross payment $2,000, in-network and out-of-network combined	**$500** copay plus **40%** of the balance of negotiated fee after annual deductible	**$500** copay plus **50%** of the balance of negotiated fee plus **100%** of excess charges after annual deductible

** Except for coverage of severe mental illness and serious emotional disturbances of a child.*

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