

**Logan County Plan 4a**  
**Blue Access<sup>SM</sup> (PPO)**  
**Summary of Benefits, Effective 01/01/2010**

| Covered Benefits   | Network  | Non-Network  |
|--|--|--|
| <b>Deductible (Single/Family)</b>  | \$500 / \$1,000  | \$1,000 / \$2,000                                      |
| <b>Out-of-Pocket Limit (Single/Family)</b>   | \$2,000 / \$4,000  | \$4,000 / \$8,000                                      |
| <b>Physician Home and Office Services (PCP/SCP)</b><br>Primary Care Physician (PCP)/Specialty Care Physician (SCP)<br>Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> <li>allergy injections (PCP and SCP)</li> <li>allergy testing</li> <li>routine and non-routine mammograms (regardless of outpatient setting)</li> <li>diabetic education (regardless of outpatient setting)</li> <li>certain medical nutritional therapy (regardless of outpatient setting)</li> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds</li> </ul>   | \$25/\$35<br><br>\$5<br>30%<br>No copayment/coinsurance<br><br>No copayment/coinsurance<br>No copayment/coinsurance<br><br>30% | 50%<br><br>50%<br>50%<br>50%<br>Not Covered<br><br>50% |
| <b>Preventive Care Services</b><br>Services include but are not limited to:<br>Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations <sup>1</sup> , Annual diabetic eye exam, Routine Vision and Hearing exams <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>   | No copayment/coinsurance<br>No copayment/coinsurance   | 50%<br>50%   |
| <b>Emergency and Urgent Care</b> <ul style="list-style-type: none"> <li><b>Emergency Room Services @ Hospital (facility/other covered services)</b> (copayment waived if admitted)</li> <li><b>Urgent Care Center Services</b></li> </ul>  | \$150<br><br>\$50  | \$150<br><br>\$50                                      |
| <b>Inpatient and Outpatient Professional Services</b><br>Include but are not limited to: <ul style="list-style-type: none"> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>   | 30%  | 50%  |
| <b>Inpatient Facility Services</b><br>Unlimited days except for: <ul style="list-style-type: none"> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days Network/Non-Network combined for skilled nursing facility</li> </ul>   | 30%  | 50%  |
| <b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>Surgery and administration of general anesthesia</li> </ul>  | 30%  | 50%  |
| <b>Other Outpatient Services (including but not limited to):</b> <ul style="list-style-type: none"> <li>Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.</li> <li>Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)</li> <li>Durable Medical Equipment and Orthotics (Network/Non-network combined) \$10,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)</li> <li>Prosthetic Devices \$10,000 benefit maximum</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>Ambulance Services</li> </ul> | 30%<br><br>30%<br>30%<br><br>30%<br>30%<br>30%<br>30%  | 50%<br><br>50%<br>50%<br><br>50%<br>50%<br>30%<br>30%  |

| Covered Benefits  | Network                     | Non-Network                 |
|---|-----------------------------|-----------------------------|
| <b>Outpatient Therapy Services<br/>(Combined Network &amp; Non-Network limits apply)</b> <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> Limits apply to: <ul style="list-style-type: none"> <li>Physical therapy: 30 visits</li> <li>Occupational therapy: 30 visits</li> <li>Manipulation therapy: 12 visits</li> <li>Speech therapy: 20 visits</li> </ul> | \$25/\$35<br>30%            | 50%<br>50%                  |
| <b>Behavioral Health Services:<br/>Mental Health and Substance Abuse<sup>2</sup></b> <ul style="list-style-type: none"> <li>Inpatient Facility Services</li> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>  | 30%<br>\$25/\$35<br>30%     | 50%<br>50%<br>50%           |
| <b>Human Organ and Tissue Transplants<sup>3</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>   | No copayment/coinsurance    | 50%                         |
| <b>Prescription Drugs<sup>4</sup></b>   | Covered under separate plan | Covered under separate plan |
| <b>Lifetime Maximum (Combined Network and Non-network)<sup>6</sup></b>  | \$5 million                 | \$5 million                 |

**Notes:**

- Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the calendar year which the child attains age 19; or to the end of the calendar year which the child attains age 25 if the child qualifies as a full time student.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan. SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year

<sup>1</sup>These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

<sup>2</sup>We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

<sup>3</sup>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

**Precertification:**

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

**Pre-existing Exclusion Period:**

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements): 12 months after the member's enrollment date. A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.