

Palomar Community College
Self-funded PPO Health Plan
Benefit Highlights

MEMBER PAYS

CO-INSURANCE

In-Network Preferred Providers Out-of-Network Providers

CALENDAR YEAR DEDUCTIBLE (all providers combined)	\$100 per individual / \$200 per family
CALENDAR YEAR STOP-LOSS MAXIMUM	After the plan has paid \$5,000 in covered expenses per member, per calendar year, the plan will pay 100% of covered expenses incurred by that member for the rest of the calendar year.

LIFETIME MAXIMUM BENEFIT

Maximum lifetime benefit per member	\$5,000,000
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MEMBER PAYS

PROFESSIONAL SERVICES

In-Network Preferred Providers Out-of-Network Providers

Visit to a physician, physician assistant or nurse practitioner	10%	30%
Routine physical examinations*	10%	30%
Well-Women care, including pap smear and mammography* (pap smear and mammography not subject to the \$200 max.)	10%	30%
Well-baby/child care* (immunizations are not part of the calendar year maximum)	10%	30%
Physician visit to hospital or skilled nursing facility	10%	30%
Surgeon or assistant surgeon	10%	30%
Administration of anesthetics	10%	30%
X-ray and laboratory procedures	10%	30%
<i>*Based on frequency recommended by the American Medical Association and \$200 maximum in a calendar year.</i>		
Outpatient Rehabilitative Therapy - Utilization review required after 30 calendar days. Speech Therapy - Limited to treatment following surgery, injury, or non-congenital disease.	10%	30%

MEMBER PAYS

CARE FOR CONDITIONS OF PREGNANCY (professional services only)

In-Network Preferred Providers Out-of-Network Providers

Prenatal and postnatal office visit	10%	30%
Normal delivery, Cesarean section. Includes newborn inpatient care.	10%	30%
Complication of pregnancy, including medically necessary abortions	10%	30%
Circumcision of newborn	10%	30%

MEMBER PAYS

OTHER SERVICES

In-Network Preferred Providers Out-of-Network Providers

Ground and air ambulance	10%	20%
Durable medical equipment.	10%	30%
Prosthesis	10%	30%
Blood, blood plasma, blood factors and blood derivatives	10%	30%
Nuclear medicine	10%	30%
Chemotherapy	10%	30%
Renal dialysis	10%	30%
Home health visit - limited to 100 visits per calendar year. In and out-of-network limits combined.	10%	30%
Hospice care	10%	30%

MEMBER PAYS

CHIROPRACTIC AND ACUPUNCTURE CARE

In-Network Preferred Providers Out-of-Network Providers

Chiropractic services	10%	30%
Acupuncture services	10%	30%
	Up to \$50 per visit. Maximum \$1,000 per calendar year.	

MEMBER PAYS**HOSPITAL AND SKILLED NURSING FACILITY SERVICES**

In-Network Preferred Providers Out-of-Network Providers

Unlimited days of hospital care in a semi-private room or ICU with ancillary services	10%	30%
Confinement in skilled nursing facility	10%	30%
Maternity care. Includes routine nursery charges	10%	30%
Outpatient surgery	10%	30%
Outpatient services (except emergency room)	10%	30%

MEMBER PAYS**EMERGENCY CARE/URGENTLY NEEDED CARE**

In-Network Preferred Providers Out-of-Network Providers

Use of emergency room (facility) Co-pay waived if admitted to hospital	10% after \$25 copay	30% after \$25 copay
Use of urgent care center (facility and professional services)	10%	30%

RETAIL PRESCRIPTIONS - EXPRESS SCRIPTS RETAIL PHARMACIES**MEMBER PAYS**

For a 30 day supply	
Generic	\$5
Brand	\$10

MAIL ORDER PRESCRIPTIONS - EXPRESS SCRIPTS MAIL SERVICE**MEMBER PAYS**

For a 90 day supply	
Generic/Brand	\$5

OUT OF AREA**MEMBER PAYS**

Out of Area refers to services received outside the United States	20% of UCR after deductible
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THIS IS ONLY A SUMMARY OF THE COVERED BENEFITS AND SERVICES. PLEASE REFER TO COVERED SERVICES AND EXCLUSIONS AND LIMITATIONS SECTIONS IN THIS BOOKLET FOR DETAILED COVERAGE INFORMATION.