

# BCBS PPO | 2023



## COMMON INSURANCE TERMS

A **PREMIUM** is the amount charged by the insurance company for coverage. Your **CONTRIBUTION** (the portion of premium that you pay) is paid through payroll deduction using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is the amount you pay to receive services. Your copayment(s) will count towards your out-of-pocket maximum but not your deductible.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, except for preventive services which are covered at 100% In-Network.

**COINSURANCE** is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

**OUT-OF-POCKET (OOP) MAXIMUM** is the most you pay per Plan Year for your health care expenses and copays and applies to deductibles, flat dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs. Once this maximum is met, the plan will cover all in-network services at 100% until the end of the plan year.

**OUT-OF-NETWORK** charges in most plans are subject to reasonable and customary limitations, which means you are responsible for charges over this amount in addition to separate deductible and coinsurance.

*This coverage is contributory which means you and USUI International Corporation, will share the cost of this benefit if you elect coverage*

In-Network Coverage	BlueCross Blue Shield (BCBSM) PPO
<b>DEDUCTIBLE</b>	
Employee Only	\$750
Employee + 1 or Family	\$1,500
<b>COINSURANCE</b>	
Insurance pays / you pay	80% / 20%
<b>COINSURANCE MAXIMUM</b>	
Employee Only	\$1,500
Employee + 1 or Family	\$3,000
<b>OUT-OF-POCKET MAXIMUM</b>	
Employee Only	\$6,600
Employee + 1 or Family	\$13,200
<b>COMMON SERVICES (Your Cost Share)</b>	
Routine Preventive	Covered at 100%
Office visit	\$30 copay
Online Physician Visit - Rendered through BC Online Visits	Covered at 100%
Specialist	20% after deductible
High-Tech Imaging	20% after deductible
Emergency Room	\$200 copay
Urgent Care	\$50 copay
<b>PRESCRIPTION DRUG COPAYS (30-Day Supply)</b>	
Generic	\$10 copay
Preferred brand	\$30 copay
Non-preferred brand	\$50 copay
Preferred specialty	20% (maximum \$100)
Non-preferred specialty	20% (maximum \$200)
<b>PRESCRIPTION DRUG MAIL ORDER (90-Day Supply)</b>	
Members must use mail order after 3 fills at a retail for Maintenance Drugs; otherwise, member will be responsible for the complete cost of the drug	
Generic	\$10 copay
Preferred brand	\$60 copay
Non-preferred brand	\$100 copay
<b>CONTRIBUTIONS BI-WEEKLY</b>	
Employee	\$55.53
Employee + One	\$133.27
Family	\$166.59

*This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, including out-of-network costs, please see the applicable certificate and riders.*