# Arrowhead West Inc

## Comprehensive Major Medical Program Dual Option - Grandfathered

**Effective January 1, 2022 – December 31, 2022**

Maximum benefits are available when services are received from Blue Choice providers. Your financial responsibility is based on the provider network you select. **Non-Blue Choice & Non-CAP:** Difference between the payment allowance and provider charge, additional 20% coinsurance amount, deductible, coinsurance or copay amount **CAP (Non-Blue Choice):** Additional 20% coinsurance amount,* deductible, coinsurance or copay amount **Blue Choice:** Deductible, coinsurance or copay amount

*Limited to a combined $2,000 per person, $4,000 two-or-more persons each benefit period.

| Member Pays | |
|---|---|
| **Dual Option** (Group Anniversary)<br>Option 1<br>Option 2 | <br>$200/$400 individual/two-or-more persons<br>$500/$1,000 individual/two-or-more persons |
| **Coinsurance** (Member portion for most services)<br>Option 1<br>Option 2 | 20% of allowed amounts after deductible has been met; up to<br>$500/$1000 individual/two-or-more persons<br>$1,000/$2,000 individual/two-or-more persons |
| **Annual Out-of-Pocket Maximum (includes deductible and coinsurance)**<br>Copays do not apply to the annual out-of-pocket amount. At the group's anniversary, an employee can upgrade no more than one deductible level within an option per benefit period. An employee can downgrade to any deductible level within an option per benefit period. | Option 1 $700/1,400 individual/two-or-more persons<br>Option 2 $1,500/$3,000 individual/two-or-more persons<br>After the annual out-of-pocket amount has been reached (ded/coins), eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period. |
| **Unlimited Lifetime Benefit. Eligible children covered to age 26.** | |
| **Covered Services** | |
| **Medical Services**<br>• Doctor Visits — home/office (including hearing and eye exam)<br>• Telemedicine Visits<br>• Surgery — inpatient and outpatient<br>• Maternity Care<br>• Well Child & Well Baby Office Visit<br>• Immunizations up to age 72 months<br>• Immunizations over 72 months<br>• Well Women — Annual Check Up<br>Office Visit<br>Mammogram<br>Pap Smear<br>• Routine Physicals — Annual Check Up<br>Office Visit<br>• Injections<br>• Outpatient Radiology and Lab Services<br>* Combined benefit period maximum. | <br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Covers 100% of maximum allowance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance |
| **Inpatient Hospital**<br>Pre-admission certification required for all planned inpatient admissions at 1-800-782-4437 | Subject to deductible/coinsurance |
| **Accidental Injury Services** | Pays 100% of allowable charges |
| **Ambulance Services** | Subject to deductible/coinsurance |

| Covered Services | |
|---|---|
| **Outpatient Hospital** | Subject to deductible/coinsurance |
| **Emergency Room Services** | Subject to deductible/coinsurance |
| **Home Health Care/Hospice** | Pays 100% of allowable charges. |
| **Freestanding Outpatient Facilities**<br>(Examples: surgery, renal dialysis) | Subject to deductible/coinsurance |
| **Medical Equipment/Disposable Supplies** | Subject to deductible/coinsurance |
| **Short-term Therapies —** Physical, Speech and Occupational, Respiratory and Cardiac | Subject to deductible/coinsurance |
| **Mental Illness & Substance Use Disorders**<br>• **Inpatient Services**<br>Requires pre-admission certification from New Directions Behavioral Health at 1-800-952-5906<br>• **Outpatient Services** | <br>Subject to deductible/coinsurance<br>Subject to deductible/coinsurance |
| **Prescription Drugs**<br>• **BlueRx Direct**<br>**BlueRx Mail (90 Day Supply)** | <br>$100/$200 deductible individual/two-or-more persons 20% coinsurance. 100 day supply limit.<br>$70 mail order copay<br>(Note: prior authorization and quantity limits may apply) |

**Exclusions:** The following procedures and all related services and supplies are not covered under this program. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression; duplicate benefits provided under federal, state or local laws, regulations or programs, except Medicaid; cosmetic or reconstructive surgery (except as stated in the certificate); any keratotomy procedures; charges for personal items; convalescent or custodial/maintenance care or rest cures; blood or payments to donors of blood; any service or supply related to the medical management of obesity; charges for services by immediate relatives or by members of your household; acupuncture and admissions for acupuncture; services related to temporomandibular joint dysfunction syndrome over the amount specified in the certificate; servic or supplies related to sex changes, sexual dysfunctions or inadequacies; any medically-aided insemination procedure; services relate to the reversal of sterilization procedures; mental illness or substance use disorder services provided by a non-eligible provider; hearing aids; eyeglasses or contact lenses (except after the removal of cataracts); unnecessary services and admissions; services o supplies which are experimental or investigative in nature; services not specifically listed as benefits in the certificate; services covere and payable by any medical expense payment provision of any automobile insurance policy.

This is a brief summary of the coverage available under this program. It is not a legal document.
The exact provisions of the benefits and exclusions are contained in the certificate.