

APP-ATT-A

Preferred Provider Organization Master Group Contract Standard Design Options

Contract Form No. _____

Group – Dept. No. _____

This Attachment may be duplicated as necessary to include additional options. Please indicate number of options here: _ _____

OPTION _____

	In-Network	Out-of-Network
Deductible:		
Individual	_____	_____
Family Maximum	_____	_____
Coinsurance Limit:		
Individual	_____	_____
Family Maximum	_____	_____
Coinsurance Percentage for:		
Hospital/Medical/Surgical	_____	_____
Inpatient Mental Illness, Drug Abuse and Alcoholism	_____	_____
Outpatient Mental Illness, Drug Abuse and Alcoholism	_____	_____
Copayment Amount for:		
Outpatient Mental Illness, Drug Abuse and Alcoholism (therapy or "unit" services)	_____	_____

- A. **Inpatient Notification, Certification and Concurrent Review:** Failure to notify BCBSNE of an inpatient admission or to certify an admission, as required, will result in a 25% _____ reduction of benefits for all covered services related to that admission. Certification denial of an admission or continued stay will result in a denial of benefits for all services determined to be not medically necessary.
- B. **Total Benefits For All Covered Services (Per Person)** - \$2,000,000 Other: _____
- C. **Total Benefits (Per Person) For Drug Abuse and Alcoholism** - \$20,000 Other: _____
- D. **Appeals Procedure Endorsement:** (B) (C) (D)
- E. **Optional Endorsements:**
 - Yes No **Office Visit Copayment for Preferred Providers**
 - Yes No **Office Services Copayment for Preferred Providers**
 - Yes No **Preventive (Routine) Care**
- F. **Family Deductible/Coinsurance:** Aggregate Embedded. If embedded, each family member must only meet the embedded single Deductible of \$_____ and the embedded Coinsurance Limit (not including the deductible) of \$_____.