

<b>BCBS PPO Medical Plan Summary Chart</b>	<b>Core</b>	<b>In-Network</b>	<b>Out-Of-Network</b>
<b><i>Deductible</i></b>			
Single	\$400	\$800	\$1,600
Family	\$1,200	\$2,400	\$4,800
<b><i>Out -Of-Pocket Maximum</i></b>			
Single	\$2,500	\$3,000	\$6,000
Family	\$5,000	\$6,000	\$12,000
Aggregate	N/A	Yes	Yes
<b><i>Physician Fees (Primary Care Office Visits)</i></b> Includes services of an internist, general physician, family practitioner or pediatrician. Also includes dermatologist, allergist and OB/GYN.	\$30 Copay	\$50 Copay	45% after Deductible
<b><i>Physician Fees (Specialist)</i></b>	\$30 Copay	\$60 Copay	45% after Deductible
<b><i>Routine Physical Exams</i></b>			
Routine Adult Physical Exams including immunizations (One exam every 12 months age 18 and over)	\$30 Copay	\$50 Copay	45% after Deductible
Routine GYN Exams (one visit per calendar year - includes Pap smear and related lab fees)	\$30 Copay	\$50 Copay	45% after Deductible
Routine Child Exams including immunizations	\$30 Copay	\$50 Copay	45% after Deductible
Routine Cancer Screening Expenses (includes routine rectal exam/prostate-specific antigen test for covered males age 40 and over)	Plan pays 100%	Plan pays 100%	45% after Deductible
Routine Cancer Screening Expenses (colorectal cancer screening for members age 50 and over done in an outpatient setting)	Plan pays 100%	Plan pays 100%	45% after Deductible
Routine Mammogram Expenses for covered females age 40 and over	Plan pays 100%	Plan pays 100%	45% after Deductible
<b><i>For Use of Urgent Care Provider - Urgent Care</i></b>	\$60 Copay	\$60 Copay	\$60 Copay
<b><i>For Emergency Room Treatment - Emergency Care</i></b>			
Per Visit Copay (waived if the person becomes confined in a Hospital)	\$150 Copay	\$150 Copay	\$150 Copay
<b><i>Ambulance Expenses</i></b>	20% after Deductible	35% after Deductible	45% after Deductible
<b><i>For Outpatient Hospital Expenses (including surgery)</i></b>	20% after Deductible	35% after Deductible	45% after Deductible
<b><i>Physician Fees for Outpatient Surgery</i></b>	20% after Deductible	35% after Deductible	45% after Deductible
<b><i>Hospital Expenses - Inpatient Coverage</i></b>	20% after Deductible	35% after Deductible	45% after Deductible
<b><i>Pre-Admission Testing Office Visit</i></b>	\$30 Copay	\$60 Copay	45% after Deductible
<b><i>Physician Fees for Routine Eye Exam Expenses (1 exam per 12 months) and Hearing (1 exam per 24 months)Non-surgical Office Also an allowance of \$100 per year combined for vision and hearing equipment and supplies.</i></b>	\$30 Copay	\$60 Copay	Only \$100 allowance

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<b><i>Other Covered Medical Expenses</i></b>			
Convalescent / Skilled Nursing Facility Expenses (120 day maximum, prior hospital confinement not required)	20% after Deductible	35% after Deductible	45% after Deductible
Home Health Care Expenses	20% after Deductible	20% after Deductible	45% after Deductible
Hospice Care Expenses (Inpatient or Outpatient, no limit or dollar maximum)	Plan pays 100% after the Deductible		45% after Deductible
Short-Term Rehabilitation / Outpatient Therapy (Speech, Physical or Occupational) 90 day maximum per year combined	\$30 Copay	\$60 Copay	45% after Deductible
Chiropractic Care / Spinal Manipulation (Limited to 20 visits per calendar year)	\$40 Copay	\$40 Copay	45% after Deductible
Durable Medical and Surgical Equipment	20% after Deductible	20% after Deductible	45% after Deductible
Allergy Testing	\$30 Copay	\$60 Copay	45% after Deductible
Allergy Serum and Injections - If a physician visit is not included then no co-pay applies	\$30 Copay	\$60 Copay	45% after Deductible
<b><i>Family Planning</i></b>			
Maternity - Initial Visit and Post Natal Care Inpatient Care	\$30 Copay 20% after Deductible	\$100 Copay 35% after Deductible	45% after Deductible
Vasectomy, Tubal Ligation and Voluntary Abortion	Coverage based on where services are rendered		45% after Deductible
Infertility Treatment Expenses (diagnosis and treatment of the underlying medical condition)	Coverage based on where services are rendered		45% after Deductible
Infertility Expenses includes ovulation inductions and insemination (up to 6 cycles in a lifetime)	Coverage based on where services are rendered		45% after Deductible
For Advanced Reproductive Technology Expenses (ZIFT and GIFT)	No Coverage	No Coverage	No Coverage
<b><i>Diagnostic Laboratory and X-Ray Expenses</i></b>			
Outpatients or Independent Lab	Plan Pays 100%	\$50 Copay	45% after Deductible
Physician office or Stand along facility	Plan Pays 100%	\$50 Copay	45% after Deductible
Exception: If the covered person receives the diagnostic X-ray services during a physician's office visit, the member will only be responsible for the Copay for the physician's office visit.			
<b><i>Diagnostic X-Ray For Complex Imaging Services (MRI, CAT scan and PET scan)</i></b>	Plan Pays 100%	\$250 Copay	45% after Deductible
<b><i>Behavioral Health Benefits (Provided by United Behavioral Health)</i></b>			
Coinsurance amounts for Behavioral Health do not apply to Out-Of-Pocket			
Inpatient Treatment	First 15 days at 10%, remaining days at 30%		50%
Outpatient Treatment	30%	30%	50%
Treatment of Drug and Alcohol Abuse	Up to 35 days of inpatient care in a non-hospital residential facility per calendar year, subject to any applicable Coinsurance		