BlueCare PPO

Group Name: Wilkes University PPO $300 Deductible
Effective Date: 6/1/2011
Renewal Date: 6/1/2012

	Insured Responsibility	
Benefits	**Preferred**	**Non-Preferred**
- Benefit period	Calendar Year	
- Deductible (maximum 3 separate per family)	$300	$600
- Coinsurance (Insured responsibility)	None	20% after deductible
- Coinsurance Maximum (maximum 3 separate per family)	None	$3,000
- Lifetime maximum	Unlimited	Unlimited
- Credit (initial benefit period only)	Not applicable	
- Precertification penalty (facility)	None	$500
Preventive Services (not subject to deductible)		
- Childhood Immunizations	No charge	20%
- Routine gynecological exam and pap smear	No charge	20%
- Routine mammography	No charge	20%
- Routine colorectal cancer and prostate cancer screening	No charge	20%
Emergency Services		
- Ambulance, emergency transport (not subject to deductible)	No charge	Amounts in excess of allowable charge
- Ambulance, non-emergency transport	No charge after deductible	20% after deductible
- Outpatient emergency room visit (not subject to deductible; copay waived if admitted to hospital)	$100	$100
- Retail clinic care	$20	20% after deductible
Inpatient Services		
- Inpatient hospital services (unlimited days per benefit period)	No charge after deductible	20% after deductible
- Skilled nursing care (60 days per benefit period)	No charge after deductible	20% after deductible
Outpatient Services		
- Chemotherapy, dialysis or radiation	No charge after deductible	20% after deductible
- High-tech imaging (MRI, MRA, CT scans, pet scans, nuclear cardiology)	$75 per test after deductible	20% after deductible
- Diagnostic testing (lab tests, x-rays, etc)	No charge after deductible	20% after deductible
- Physical (20 visits per benefit period), speech (12 visits per benefit period), or occupational therapy (12 visits per benefit period)	$40 after deductible	20% after deductible
- Cardiac rehabilitation (36 visits/benefit period)	No charge after deductible	20% after deductible
- Pulmonary/Respiratory therapy (18 visits per therapy per benefit period)	No charge after deductible	20% after deductible
Other Services		
- Chiropractic manipulative benefits (12 visits per benefit period ages 13 and up)	$40 after deductible	20% after deductible
- Durable medical equipment/orthotics/prosthetics (unlimited maximum)	No charge after deductible	20% after deductible
- Home health services/Home infusion (nurse visits)	$40 after deductible	20% after deductible
- Hospice care (180-day lifetime maximum)	No charge after deductible	20% after deductible
- Surgery	No charge after deductible	20% after deductible
- Maternity services (physician office visits) (preferred not subject to deductible)	$40 initial visit	20% after deductible
- Primary Care Physician office visits (preferred not subject to deductible; unlimited visits)	$20	20% after deductible
- Specialty Care Physician office visits (preferred not subject to deductible; unlimited visits)	$40	20% after deductible
Mental Health and Substance Abuse Services		
- Outpatient mental health services (unlimited)	No charge after deductible	20% after deductible
- Inpatient mental health services (unlimited days)	No charge after deductible	20% after deductible
- Outpatient substance abuse services (unlimited)	No charge after deductible	20% after deductible
- Detoxification (unlimited days)	No charge after deductible	20% after deductible
- Inpatient non-hospital residential substance abuse treatment (unlimited days)	No charge after deductible	20% after deductible
Prescription drugs		
- Deductible (per benefit period)	None	None
- Retail, 30-day supply	$0/$15/$30/$50	Special Circumstances
- Mail order program, up to a 90-day supply	$0/$30/$70/$150	None
- Oral contraceptives	Covered	None

The deductible applies to all services unless otherwise noted above.

The allowable charge is established by a provider agreement or is the billed amount, whichever is less, and will be accepted by the preferred provider as payment in full for covered services less any deductibles, coinsurance, copayments, and amounts exceeding any benefit maximums. For a non-preferred provider, the allowable charge is the same amount First Priority Life would pay to a preferred provider.

This is an abridged overview of the benefits covered by BlueCare® PPO. This highlights general features and is not intended to be a substitute for the terms, provisions, limitations and conditions imposed by the controlling policies. Since benefits are reviewed annually and are often modified, if there is a condition that you are treated for on a regular basis, be sure to inquire about your specific coverage needs. ASO1/11