

## BLUE ADVANTAGE HMO 2018 BENEFIT PLAN SUMMARY

Medical care must be coordinated through your chosen Medical Group, with the exception of eye exams which are obtained through EyeMed Vision participating providers.

Summary of Benefits	Member Cost
<p><b>Physician Services</b></p> <p>Office Visits: Primary Care Physician</p> <p>Referred Specialist Care</p> <p>Well Care for Adults and Children</p> <ul style="list-style-type: none"> <li>- Physical Checkups</li> <li>- Preschool/School Physicals (excluding Sports Physicals)</li> <li>- Immunizations</li> <li>- Women's Preventive Health Services</li> </ul>	<p>\$25 co-pay</p> <p>\$40 co-pay</p> <p>All well care physician visits \$0 co-pay. If well care visit includes treatment for medical condition, a co-pay may be charged.</p>
<p><b>Out of Pocket Maximum</b></p>	<p>\$1,800 single, \$3,600 family</p>
<p><b>Vision Care</b></p> <p>Annual Routine Eye Examinations (all ages), single vision lenses, bifocal lenses, trifocal lenses, lenticular lenses, contact lenses and frames.</p> <p>EyeMed has over 70,000 independent, licensed providers and major retailers like LensCrafters, Pearle VisionSM, Target OpticalSM, Sears Optical and JCPenney Optical. Call EyeMed Customer Care Center at 844-684-2254 for an exact list of the participating provider listing.</p>	<p>Eye exam \$0 every 12 months.</p> <p>Lenses and contact lenses \$75 allowance.</p> <p>Frame \$125 allowance.</p> <p>Benefits are limited to one pair of lenses and a frame per benefit period that is equal to 24 months</p> <p>*Note: If there is a medical condition related to the eye, a referral is required to a specialist and a \$40 co-pay will apply.</p>
<p><b>Hospital Care</b></p> <p>Semiprivate Room (unlimited days)</p> <p>Intensive Care / Specialty Unit</p> <p>Physician Visit</p> <p>Operating and Recovery Room</p> <p>X-ray, Lab, Medications</p> <p>Skilled Nursing Facility</p> <p>In-patient Hospice</p>	<p>Each hospital admission \$200/day for the first 5 days to a maximum of \$1,000 per calendar year.</p>
<p><b>Surgery</b></p> <p>Surgeon, Anesthesiologist, Consultations</p>	<p>Outpatient surgery \$150.</p> <p>Inpatient surgery included with inpatient hospital coverage.</p>
<p><b>Maternity</b></p> <p>Prenatal, Delivery and Postnatal Care</p>	<p>\$25 co-pay for initial visit only. Then 100% until delivery. Each hospital admission \$200/day for first five days to a maximum of \$1,000 per calendar year.</p>

Summary of Benefits	Member Cost
<p><b>Mental Health and Substance Abuse</b></p> <p>Outpatient</p> <p>Inpatient</p>	<p>\$25 co-pay per visit.</p> <p>Each hospital admission \$200/day for first Five days to a maximum of \$1,000 per calendar year .</p>
<p><b>Emergency</b></p> <p>Services received in a hospital emergency room. All follow-up care must be provided or coordinated by your PCP. Urgent Care Facility (must be affiliated with member's medical group).</p>	<p>\$150 co-pay, waived if admitted to hospital.</p> <p>\$25 co-pay.</p>
<p><b>Outpatient Rehabilitative Therapy</b></p> <p>Includes: Speech, Physical and Occupational Therapy (60 treatments combined/calendar year.)</p>	<p>\$25 co-pay per visit.</p>
<p><b>Diagnostic Tests</b></p> <p>Outpatient Laboratory Tests and X-rays.</p>	<p>Provided in full. No employee cost.</p>
<p><b>Other Covered Services</b></p> <p>Ambulance Service</p> <p>Durable Medical Equipment</p> <p>Prosthetic Devices (leg, arm and neck braces)</p> <p>Diabetic Supplies</p>	<p>Provided in full. No employee cost.</p>
<p><b>Prescription Drugs</b></p> <p>Generic – (34 day supply)</p> <p>Formulary Brand – (34 day supply)</p> <p>Non-Formulary Brand – (34 day supply)</p> <p>Specialty Drugs</p> <p><b>Mail Order/Retail 90 Prescription Drugs (Maintenance Drugs)</b></p> <p>Generic – (90 day supply)</p> <p>Formulary Brand – (90 day supply)</p> <p>Non-Formulary Brand – (90 day supply)</p> <p>*Note: Certain women's preventive services and prescriptions will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service at 1-800-892-2803.</p> <p>When a generic drug is available, participant must use generic or pay non-formulary brand co-pay plus the cost difference between</p>	<p>\$12 co-pay</p> <p>\$30 co-pay</p> <p>\$45 co-pay</p> <p>\$140 co-pay</p> <p>\$30 co-pay</p> <p>\$75 co-pay</p> <p>\$112 co-pay.</p>

Summary of Benefits	Member Cost
the generic and non-formulary brand.	

**Delta Dental PPO Dental Plan** (Can take alone or with health care plan.)

\$100 individual annual deductible, \$300 family; plan pays 75%, patient 25% for dental work. Diagnostic and preventive services paid at 100% of eligible charge each calendar year include 2 cleanings and exams, 2 bite-wing x-rays, 1 fluoride treatment. 1 complete full mouth x-ray allowed in 36 month interval. Calendar year maximum per person \$2000. Orthodontic lifetime maximum per person \$2000.