**BlueCare PPO**

**Group Name:** Wilkes University 051317000, 051317099  
**Effective Date:** 6/1/2012  
**Renewal Date:** 6/1/2013

### Benefits

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year</strong></td>
<td><strong>Deductible (3 per family)</strong></td>
</tr>
<tr>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Coinsurance (Insurance responsibility)</strong></td>
<td><strong>Coinsurance Maximum (3 per family)</strong></td>
</tr>
<tr>
<td>30% of allowable charge</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Lifetime maximum</strong></td>
<td><strong>Unlimited</strong></td>
</tr>
<tr>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Credit (initial benefit period only)</strong></td>
<td><strong>Not applicable</strong></td>
</tr>
<tr>
<td>None</td>
<td>$500</td>
</tr>
</tbody>
</table>

#### Preventive Services (not subject to deductible)

- **Childhood Immunizations**: No charge 50%
- **Routine gynecological exam and pap smear**: No charge 50%
- **Routine mammography**: No charge 50%
- **Routine colorectal cancer and prostate cancer screening**: No charge 50%

#### Emergency Services

- **Ambulance, emergency transport (not subject to deductible)**: 30%
- **Ambulance, non-emergency transport**: 30% after deductible 50% after deductible
- **Outpatient emergency room visit (not subject to deductible; copay waived if admitted to hospital)**: $100 $100
- **Retail clinic care (Preferred not subject to deductible)**: $25 50% after deductible
- **Urgent Care (Preferred not subject to deductible)**: $50 50% after deductible

#### Inpatient Services

- **Inpatient hospital services (unlimited days per benefit period)**: 30% after deductible 50% after deductible
- **Skilled nursing care (60 days per benefit period)**: 30% after deductible 50% after deductible

#### Outpatient Services

- **Chemotherapy, dialysis or radiation**: 30% after deductible 50% after deductible
- **High-tech imaging (MRI, MRA, CT scans, pet scans, nuclear cardiology)**: 30% after deductible 50% after deductible
- **Diagnostic testing (lab tests, x-rays, etc)**: 30% after deductible 50% after deductible
- **Physical (20 visits per benefit period), speech (12 visits per benefit period), or occupational therapy (12 visits per benefit period)**: 30% after deductible 50% after deductible
- **Cardiac rehabilitation (36 visits/benefit period)**: 30% after deductible 50% after deductible
- **Pulmonary/Respiratory therapy (18 visits per therapy per benefit period)**: 30% after deductible 50% after deductible

#### Other Services

- **Chiropractic manipulative benefits (12 visits per benefit period ages 13 and up)**: 30% after deductible 50% after deductible
- **Durable medical equipment/orthotics/prosthetics (unlimited maximum)**: 30% after deductible 50% after deductible
- **Home health services/Home infusion (nurse visits)**: 30% after deductible 50% after deductible
- **Hospice care (180-day lifetime maximum)**: 30% after deductible 50% after deductible
- **Surgery**: 30% after deductible 50% after deductible
- **Maternity services (physician office visits) (preferred not subject to deductible)**: $50 initial visit 50% after deductible
- **Primary Care Physician office visits (preferred not subject to deductible; unlimited visits)**: $25 50% after deductible
- **Specialty Care Physician office visits (preferred not subject to deductible; unlimited visits)**: $50 50% after deductible

#### Mental Health and Substance Abuse Services

- **Outpatient mental health services (unlimited)**: 30% after deductible 50% after deductible
- **Inpatient mental health services (unlimited days)**: 30% after deductible 50% after deductible
- **Outpatient substance abuse services (unlimited)**: 30% after deductible 50% after deductible
- **Detoxification (unlimited days)**: 30% after deductible 50% after deductible
- **Inpatient non-hospital residential substance abuse treatment (unlimited days)**: 30% after deductible 50% after deductible

#### Prescription drugs

- **Deductible (per benefit period)**: $100
- **Retail, 30-day supply**: $0/$15/$30/$50
- **Mail order program, up to a 90-day supply**: $0/$30/$70/$150
- **Contraceptives**: Covered

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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.