

EVIDENCE OF COVERAGE PPO SCHEDULE OF BENEFITS
BLUE NETWORK P PROVIDER NETWORK
 Effective Date January 1, 2007

Covered Services	Network Providers	Out-of-Network Providers
Practitioner Services (physician, specialist or nurse practitioner)		
Allergy Testing	80% after Deductible	60% after Deductible
Injections (including allergy serum)	100%	60% after Deductible
Maternity Services	\$25 Co-payment first visit only	60% after Deductible
Office Services	\$25 Co-payment per visit	60% after Deductible
Routine diagnostic services	100%	60% after Deductible
Facility Services		
Emergency Care Services	80% after Deductible	80% after Deductible
Inpatient Hospital	80% after Deductible	60% after Deductible
Non-routine Diagnostic Services	80% after Deductible	60% after Deductible
Outpatient Surgery	80% after Deductible	60% after Deductible
Skilled Nursing/Rehab	80% after Deductible	60% after Deductible
Preventive Services		
Annual Well Woman Exam (includes mammography & cervical cancer screening)	\$25 Co-payment per visit	60% after Deductible
Immunizations (to age 6)	100%	60% after Deductible
Prostate Screening	\$25 Co-payment per visit	60% after Deductible
Well Child Care (to age 6)	\$25 Co-payment per visit	60% after Deductible
Well Care - adult or child over 6 yrs (limited to \$300 and one exam per yr)	\$25 Co-payment per visit	60% after Deductible
Other Services		
Ambulance	80% after Deductible	80% after Deductible
Behavioral Health		
Inpatient - 30 days per year	80% after Deductible	60% after Deductible
Outpatient - 40 visits per year	80% after Deductible	60% after Deductible
Chiropractic Care (limited to 30 visits per year)	\$25 Co-payment per visit	60% after Deductible
Durable Medical Equipment	80% after Deductible	60% after Deductible
Home Health Services (limited to 60 visits per year)	80% after Deductible	60% after Deductible
Hospice	100%	60% after Deductible
Organ Transplants	80% after Deductible	60% after Deductible
Supplemental Accident (up to \$500 per year)	100%	100%
Therapeutic Services (limited to 60 visits per therapy per yr)	80% after Deductible	60% after Deductible
TMJ Treatment (limited to \$1,500 per year)	80% after Deductible	60% after Deductible
Annual Deductible		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000
4th Quarter Deductible Carryover	Yes	
Annual out-of-pocket		
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000
Lifetime Maximum	\$5,000,000.00	
Prescription Drugs	\$15 Co-payment for Generic Drugs \$35 Co-payment for Preferred Brand Name Drugs \$50 Co-payment for Elective Brand Name Drugs 102 - day Supply - Mail Order (2 times co-pay amount)	

See Evidence of Coverage Booklet for more information