## **Simply Blue Direct Pay**

## SUMMARY OF BENEFITS<sup>1</sup>

Effective Date			
Benefit Period (used for Deductible and Coinsurances limits)	January 1 through December 31 (Calendar Year)		
Deductible (Network and Non-Network Deductibles cross apply)	Ne Silver Option	twork <i>Bronze Option</i>	Non- Network
Individual	\$1,000	\$2,000	\$4,000
Family (may be met collectively)  Note: All services are subject to the Deductible unless otherwise specified.	\$2,000	\$4,000	\$8,000
Carry-Over Deductible Period	October, November and December		and December
Coinsurance Limit (Network and Non-Network Coinsurance dollars do not cross apply)	Network		Non- Network
Individual	· ·	5,000	\$6,000
Family (may be met collectively)	· ·	0,000 twork	\$12,000 Non- Network
Maximum Out-of-Pocket	Silver Option	Bronze Option	Non- Network
Individual	\$6,000	\$7,000	\$10,000
Family (may be met collectively)	\$12,000	\$14,000	\$20,000
Non-Network Liability	Unlimited		
Lifetime Maximum Benefit for all Covered Services	Unlimited		
BENEFIT	HIGHLIGHTS	3	
	NET	WORK <sup>2</sup>	NON-NETWORK <sup>2</sup>
Primary Care Provider Medical Office Visit / Office Consultation - Applies to Charges for Visit only. Does not apply to other Services received during Visit. Office Visit Fees do not apply to Deductible or Coinsurance limits. Co-Pays do not apply for certain preventive visits. See the Preventive section for this information.	1 <sup>st</sup> visit: \$20 per Office Visit, 100% thereafter, No Deductible Subsequent Visits: \$35 per Office Visit, 100% thereafter, No Deductible		60%
Specialist Care Medical Office Visit / Office Consultation - Applies to Charges for Visit only. Does not apply to other Services received during Visit. Office Visit Fees do not apply to Deductible or Coinsurance limits. Co-Pays do not apply for certain preventive visits. See the Preventive section for this information.	\$50 per Office Visit, 100% thereafter, No Deductible		60%
Urgent Care Center Medical Office Visit / Office Consultation - Applies to Charges for Visit only. Does not apply to other Services received during Visit. Office Visit Fees do not apply to Deductible or Coinsurance limits. Co-Pays do not apply for certain preventive visits. See the Preventive section for this information.	\$50 per Office Visit, 100% thereafter, No Deductible		\$50 per Office Visit, 60% thereafter
Prescription Drugs are provided through a Retail Pharmacy Network If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. Maximum 34 day supply.	50% Generic 50% Brand No Deductible		No Benefits
Mail Order Drugs - If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists.  Maximum 90 day supply.	50% Generic 50% Brand No Deductible		No Benefits
Additional Prescription Benefits <sup>3</sup> (Retail or Mail Order) - Adults: Aspirin, Smoking Cessation, Folic Acid, Children: Iron Supplements and Oral Fluoride (guidelines as determined by certain Governmental Agencies) – You may access this information at <a href="https://www.healthcare.gov">www.healthcare.gov</a> . You may also contact Member Services.	100%, No Deductible		No Benefits

PHYSICIAN SERVICES   80%   60%	PREVENTIVE CARE SERVICES		
Annual Gynecological Exam - one per Calendar year.  Routine Pay Testing - one every 3 years ago 30 and older  Routine Pay Testing - one every 3 years ago 30 and older  Routine Pay Testing - one every 3 years ago 30 and older  Prostate Exam - one per Calendar year 100%, No Deductible 60%  Routine Mammogram - per schedule age 35 and older  100%, No Deductible 60%  Prostate Specific Antigen (PSA) Test - one per Calendar year 100%, No Deductible 60%  Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per Calendar year 100%, No Deductible 60%  Focal ocut blood test - one per Calendar year 100%, No Deductible 60%  Focal ocut blood test - one per Calendar year 100%, No Deductible 60%  Focal ocut blood test - one per Calendar year 100%, No Deductible 60%  Coloroscopy - one every 5 years 100%, No Deductible 60%  Focal ocut blood test - one per Calendar year 100%, No Deductible 60%  Routine Streening, Immunization and Diagnostic Services 100%, No Deductible 60%  Routine Screening, Immunization and Diagnostic Services 100%, No Deductible No Benefits 100%, No Deductible 60%  Routine Screening, Immunization and Diagnostic Services 100%, No Deductible No Benefits 100%, No Deductible 80%  Routine Immunization Services 100%  Routine Diagnostic Services 100%  Routine Diagnostic Services 100%, No Deductible 80%  Routine Diagnostic Services 100%  Routine Immunization Services 100%  Routine Diagnostic Services 100%		NETWORK <sup>2</sup>	NON-NETWORK <sup>2</sup>
Routine Pag Smear - one per Calendar year  Routine Mammogram - per schedule age 35 and older  Routine Mammogram - per schedule age 35 and older  Routine Mammogram - per schedule age 35 and older  Prostate Exam - one per Calendar year for males over age 50.  Prostate Specific Amgien (PSA) Test - one per Calendar year 100%, No Deductible  60%  Routine Mammogram - per schedule age 35 and older  Colorectal Cancer Exam - for individual's age 50 and older or a symptomate person under age 50. One per Calendar year  Flexal to Colorectal Cancer Exam - for individual's age 50 and older or a symptomate person under age 50. One per Calendar year  Flexal to Colorectal Cancer Exam - for individual's age 50 and older or a symptomate person under age 50. One per Calendar year  Flexal to Colorectopy - one every 5 years  100%, No Deductible  60%  Flexible Sigmodiscopy - one every 5 years  100%, No Deductible  60%  Routine Physical Exam - one per Calendar year  100%, No Deductible  60%  Routine Physical Exam - one per Calendar year  100%, No Deductible  700%, No	Annual Gynecological Exam - one per Calendar year.	100%, No Deductible	
Routine HPV Testing - one every 3 years age 30 and older Prostate Exam - one per Calendar year for males over age 50. Prostate Exam - one per Calendar year for males over age 50. Prostate Specific Antigen (PSA) Test - one per Calendar year 100%, No Deductible 60% Prostate Specific Antigen (PSA) Test - one per Calendar year 100%, No Deductible 60% Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per Calendar year 100%, No Deductible 60% Freed acout blood test - one per Calendar year 100%, No Deductible 60% Colonoscopy - one every 5 years 100%, No Deductible 60% Colonoscopy - one every 10 years 100%, No Deductible 60% Colonoscopy - one every 10 years 100%, No Deductible 60% Colonoscopy - one every 5 years 100%, No Deductible 60% Colonoscopy - one every 10 years 100%, No Deductible 60% Colonoscopy - one every 10 years 100%, No Deductible 60% Colonoscopy - one every 10 years 100%, No Deductible 60% Colonoscopy - one every 10 years 100%, No Deductible No Benefits Colored Exam - one per Calendar year 100%, No Deductible No Benefits Colored Exam - one per Calendar year 100%, No Deductible No Benefits Colored Exam - one per Calendar year 100%, No Deductible No Benefits Colored Exam - one per Calendar year 100%, No Deductible No Benefits Colored Exam - one per Calendar year 100%, No Deductible No Benefits Colored Exam - one per Calendar year 100%, No Deductible 60% Colored Exam - one per Calendar year 100%, No Deductible 60% Colored Exam - one per Calendar year 100%, No Deductible 60% Colored Exam - one per Calendar year 100%, No Deductible 60% Colored Exam - one per Calendar year 100%, No Deductible 100%, No Deductible 60% Colored Exam - one per Calendar year 100%, No Deductible 100%, No Deduc		100%, No Deductible	60%, No Deductible
Prostate Exam - one per Calendar year for males over age 50. Prostate Specific Antigen (PSA) Test - one per Calendar year Colorectal Cancer Exam - for individual's age 80 and older or a symptomatic parson under age 50. One per Calendar year Feat accust blood test - one per Calendar year Feat accust blood test - one per Calendar year Flexible Sigmoldoscopy - one every 5 years 100%, No Deductible 60% Gordonoscopy - one every 10 years 100%, No Deductible 60% Gordonoscopy - one every 5 years 100%, No Deductible 60% Gordonoscopy - one every 10 years 100%, No Deductible 60% Routine Playsical Exam - one per Calendar year 100%, No Deductible 60% Routine Playsical Exam - one per Calendar year 100%, No Deductible No Benefits Routine Sersening, Immunization and Diagnostic Services' (guideline sa determined by certain governmental agencies) - You may access this information at yeave health-gar gozy. You may also contact Member Services: Routine Immunization Services: Will, Expatitis A & Series and Meningoeoccal vaccinations Routine Diagnostic Services: Upid panel, complete blood count and blood glucose screening.  Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  Well Child Care - Routine Office Visits and immunizations age 6  In-tospital Medical Visit  Well Child Care - Routine Office Visits and immunizations age 6  In-tospital Medical Visit  Second Surgical Opinion Consultations (Outpatient)  (Bo%)		100%, No Deductible	60%
Prostate Exam - one per Calendar year for males over age 50. Prostate Specific Amplian (PSA) Test - one per Calendar year Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per Calendar year Fecal occult blood test - one	<u> </u>	100%, No Deductible	60%
Prostate Specific Antigen (PSA) Test - one per Calendar year Colorecta Concer Stam - for individual's age 50 and older or a symptomatic person under age 50. One per Calendar year. Fexal occult blood test - one per Calendar year Flexible Sigmiotiscopy - one every 10 years Colonoscopy - one every 10 years 100%, No Deductible 60% Colonoscopy - one every 10 years 100%, No Deductible 60% Routine Physical Exam - one per Calendar year Flexible Sigmiotiscopy - one every 10 years 100%, No Deductible 60% Routine Physical Exam - one per Calendar year Routine Physical Exam - one per Calendar year Routine Strending, Immunization and Diagnostic Services¹ (guidelines as determined by certain governmental agencies) - You may access this information at www.healthbazer.ogu. You may also contact Member Services. Routine Influenza, Varicella, Hepatitis A & B Series and Meningooccal vaccinations Routine Diagnostic Services: Lipid panel, complete blood count and blood gluces services Lipid panel, complete blood count and blood gluces services Lipid panel, complete blood count and blood gluces services urinalysis and rubella titer test 80% 60%  WELL BABY / CHILD CARE SERVICES³  Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  Well Child Care - Routine Office Visits, lab tests and immunizations age 6 through 17.  PHYSICIAN SERVICES  In-Hospital Medical Visit Surgery, Assistant 6 Surgery, Anesthesia  Surgery Assistant 6 Surgery, Anesthesia  Surgery Assistant 6 Surgery, Anesthesia  Surgery Assistant 6 Surgery, Anesthesia  (Rowship Calendar year).  Physical Therapy- Note: Limitations are to Physician and Outpatient for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance Imits. 10 visit Maximum per Calendar year, Coinsurance amounts for these Services do not apply to your Coins		•	60%
Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per Calendar year.  Facal occult blood test - one per Calendar year.  Facal occult blood test - one per Calendar year.  Facal occult blood test - one per Calendar year.  Facal occult blood test - one per Calendar year.  Flexible Sigmoidoscopy - one every 15 years  Colonoscopy - one every 19 years  Bouthe Contrast Barum Enema - one every 5 years  Routine Physical Exam - one per Calendar year  100%, No Deductible  60%  Routine Physical Exam - one per Calendar year  100%, No Deductible  700%, No Deductible  80%  No Benefits  No Benefits  No Benefits  No Benefits  No Benefits  No Benefits  100%, No Deductible  100%, No Deductible  60%  Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening  Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening  Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening  Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening  Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening  Routine Diagnostic Services United and immunizations to age 6.  Diabetes Education & Control  WELL BABY / CHILD CARE SERVICES <sup>3</sup> Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  PHYSICIAN SERVICES  In-Hospital Medical Visit  Surgery, Assistant to Surgery, Anesthesia  Routine Diagnostic Services on the physician and Cuptatient (Physician and Cuptatient)  No Benefits  Routine Diagnostic Services on the physician and Cuptatient (Physician and Cuptatient Facility Services combined (per Calendar year).  Cocupational Therapy- Note: Limitations are for Physician and Cuptatient Facility Services conduct facility Ser	·		60%
Fecal cocult blood test - one per Calendar year Flexible Signoidoscop- one every 5 years 100%, No Deductible 60% Colonoscopy - one every 10 years 100%, No Deductible 60% Routine Sergening, Immunization and Diagnostic Services Routine Sergening, Immunization and Diagnostic Services (guidelines as determined by certain governmental agencies) - You may access this information at www.healthcare.gov. You may also contract Member Services. Routine Immunization Services: MMR, Pneumococcal Polysaccardia, Influenza, Varicella, Hepatitis A & B Series and Meningococcal vaccinations Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening  Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  Well Child Care – Routine Office Visits and immunizations age 6 In-Hospital Medical Visit  Burgery, Assistant to Surgery, Anesthesia  Burgery, Note: Limitations are covered. (Covered only when purchasing the Materinty index).  Physical Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year).  Consurance Immis. 10 visit Maximum per Calendar year.  Consurance Immis. 10 visit Maxim	Colorectal Cancer Exam - for individual's age 50 and older or a		60%
Flexible Sigmoidoscopy - one every 10 years Colonoscopy - one every 10 years Double Contrast Barium Enema - one every 5 years Double Contrast Barium Enema - one every 5 years Double Contrast Barium Enema - one every 5 years Double Contrast Barium Enema - one every 5 years Double Contrast Barium Enema - one every 5 years 100%, No Deductible No Benefits  N		100%. No Deductible	60%
Colonoscopy - one every 10 years Double Contrast Barlum Enema - one every 5 years 100%, No Deductible 60% Routine Physical Exam - one per Calendar year 100%, No Deductible 100%, No Deductible No Benefits Routine Screening, Immunization and Diagnostic Services² (guidelines as determined by certain governmental agencies) - You may access this information at www.healthcate.gov. You may also contact Member's Services. Routine Immunization Services: MMR, Pneumococcal Polysaccaride, Influenza, Varicella, Hepatitis A & B Series and Meningococcal vaccinations Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood Count and blood glucose screening Routine Diagnostic Services Lipid panel, complete blood Count and blood glucose screening  Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  Well Child Care – Routine Office Visits and immunizations age 6  In-Hospital Medical Visit  Surgery, Assistant to Surgery, Anesthesia  Second Surgical Opinion Consultations (Outpatient)  In-Hospital Medical Visit  Surgery, Assistant to Surgery, Anesthesia  Second Surgical Opinion Consultations (Outpatient)  Physical Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year).  Coinsurance limits. 10 visit Maximum per Calendar year).  Coinsurance Immits. 10 visit Maximum per Calendar year).  Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to you			60%
Double Contrast Barium Enema - one every 5 years  Routine Physical Exam - one per Calendar year  Routine Physical Exam - one per Calendar year  Routine Screening, Immunization and Diagnostic Services <sup>1</sup> (guidelines as determined by certain governmental agencies) - You  ray access this information at yeav-healthcare you. You may also  contact Member Services.  Routine Physical Exam - one per Calendar year.  Routine Services (Sandar Services) - You who althcare you who you who you who you who y			60%
Routine Physical Exam - one per Calendar year  Routine Screening, Immunization and Diagnostic Services <sup>3</sup> (guidelines as determined by certain governmental agencies) - You may access this information at www.healthcare.gov. You may also contact Member Services.  Routine Immunization Services. IMRR, Pneumococcal Polysaccande, Influenza, Variotella, Hepatits & & B Series and Meningococcal vaccinations  Routine Immunization Services. Lipid panel, complete blood count and blood glucose screening  Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening  Routine Diagnostic Services: urinalysis and rubella titer test  B0% 60%  Both 60%  WELL BABY / CHILD CARE SERVICES <sup>3</sup> Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine Office Visits and immunizations age 6  Well Child Care - Routine		-	60%
Routine Screening, Immunization and Diagnostic Services (guidelines as determined by certain governmental agencies) — You may also contact Member Services.  Routine Immunization Services: MMR, Pneumococcal Polysaccaride, Influenza, Varicella, Hepatitis A & B Series and 100%, No Deductible 60% Memingococcal vaccinations.  Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services: Lipid panel, complete blood count and blood glucose screening Routine Diagnostic Services: urinalysis and rubella titer test 80% 60% 60% 10 members of the Services and rubella titer test 80% 60% 10 members of the Services of the Services and Individual to the Services of the			No Benefits
Polysaccaride, Influenza, Varicella, Hepatitis A & B Series and Meningococcal vaccinations Meningococcal vaccinations (Meningococcal vaccinations) (Meningococcal	Routine Screening, Immunization and Diagnostic Services <sup>3</sup> (guidelines as determined by certain governmental agencies) – You may access this information at <a href="https://www.healthcare.gov">www.healthcare.gov</a> . You may also		No Benefits
Blood glucose screening Routine Diagnostic Services: urinalysis and rubella titer test  Biabetes Education & Control  WELL BABY / CHILD CARE SERVICES  Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  through 17.  PHYSICIAN SERVICES  In-Hospital Medical Visit Surgery, Assistant to Surgery, Anesthesia Second Surgical Opinion Consultations (Outpatient) Metarnity Care - Dependent daughters are covered. (Covered only Men purchasing the Maternity rider.)]  [Rewborn Care including circumcision.]  Physical Therapy- Note: Limitations are for Physician and Outpatient Teacility Services combined (per Calendar year).  Coinsurance amounts for these Services do not apply to your Coinsurance (per Calendar year).  Coinsurance Imits. 10 visit Maximum per Calendar year.  Coinsurance Imits. 10 visit Maximum per Calendar year.  Speech Therapy When necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year).  Coinsurance Imits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year).  Coinsurance Imits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services do not apply to your Coinsurance (per Calendar year).  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services on on the Services on on tapply to your Coinsurance Imits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services on these Services do not apply to your Coinsurance Imits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services on the Service	Polysaccaride, Influenza, Varicella, Hepatitis A & B Series and	100%, No Deductible	60%
Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.   100%, No Deductible   100%,		100%, No Deductible	60%
Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.  Well Child Care — Routine Office Visits and immunizations age 6  Well Child Care — Routine Office Visits and immunizations age 6  Well Child Care — Routine Office Visits and immunizations age 6  In-Hospital Medical Visit  PHYSICIAN SERVICES  In-Hospital Medical Visit  Surgery, Assistant to Surgery, Anesthesia  80%  Second Surgical Opinion Consultations (Outpatient)  In Macrinity Care — Dependent daughters are covered. (Covered only when purchasing the Maternity rider.)]  In No Benefits  In	Routine Diagnostic Services: urinalysis and rubella titer test	80%	60%
Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.   100%, No Deductible   100%,	Diabetes Education & Control	80%	60%
Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.   100%, No Deductible   100%,	WELL BABY / CHIL	D CARE SERVICES <sup>3</sup>	
Well Child Care – Routine Office Visits and immunizations age 6 through 17.  PHYSICIAN SERVICES  In-Hospital Medical Visit  80% 60%  Surgery, Assistant to Surgery, Anesthesia 80% 60%  Second Surgical Opinion Consultations (Outpatient) 10%, No Deductible 100%, No Ded		100%, No Deductible	100%, No Deductible
In-Hospital Medical Visit   80%   60%		100%, No Deductible	100%, No Deductible
Surgery, Assistant to Surgery, Anesthesia  Second Surgical Opinion Consultations (Outpatient)  Indexentity Care - Dependent daughters are covered. (Covered only when purchasing the Maternity rider.)]  [Rowborn Care including circumcision.]  [No Benefits]  [No B	PHYSICIAI	N SERVICES	
Second Surgical Opinion Consultations (Outpatient)   100%, No Deductible   100%, No De		80%	60%
Maternity Care - Dependent daughters are covered. (Covered only when purchasing the Maternity rider.)]   [No Benefits]   [No Benefits]   [No Benefits]   [Rowborn Care including circumcision.]   [Rowb			
No Benefits			
[80%]   [60%]   [No Benefits]   [60%]   [No Benefits]   [No Deductible   [No			
Physical Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.  Occupational Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year). Coinsurance limits. 10 visit Maximum per Calendar year.  Chiropractic Manipulations- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance mounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Coinsurance amounts for these Services do not apply to your Services (Cardiac Rehab, Chemotherapy , Radiation Row Maximum per Calendar year.  Therapy Services (Cardiac Rehab, Chemotherapy , Radiation Row Maximum per Calendar year).  Temporomandibular Joint Dysfunction / Craniomandibular Row Maximum per Calendar year.	, ,,,,		
Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit  Maximum per Calendar year.  Occupational Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year).  Coinsurance amounts for these Services do not apply to your  Coinsurance limits. 10 visit Maximum per Calendar year.  Chiropractic Manipulations- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year).  Coinsurance amounts for these Services do not apply to your  Coinsurance limits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network  Coinsurance amounts for these Services do not apply to your  Coinsurance limits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network  Coinsurance amounts for these Services do not apply to your  Coinsurance limits. 10 visit Maximum per Calendar year.  Therapy Services (Cardiac Rehab, Chemotherapy , Radiation  Therapy and Dialysis)  Temporomandibular Joint Dysfunction / Craniomandibular  Disorders  So per visit, 100% thereafter No Deductible  60%  60%  60%  60%	[Newborn Care including circumcision.]		
Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.  Chiropractic Manipulations- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.  Therapy Services (Cardiac Rehab, Chemotherapy , Radiation Therapy and Dialysis)  Temporomandibular Joint Dysfunction / Craniomandibular Disorders  \$50 per visit, 100% thereafter No Deductible  \$50 per visit, 100% thereafter No Deductible  \$60%  \$60%  \$60%	Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. <b>10 visit</b>		60%
Outpatient Facility Services combined (per Calendar year).  Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.  Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.  Therapy Services (Cardiac Rehab, Chemotherapy, Radiation Therapy and Dialysis)  Temporomandibular Joint Dysfunction / Craniomandibular Disorders  \$50 per visit, 100% thereafter No Deductible  \$50 per visit, 100% thereafter No Deductible  \$60%  60%  60%	Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your		60%
Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.  Therapy Services (Cardiac Rehab, Chemotherapy, Radiation Therapy and Dialysis)  Temporomandibular Joint Dysfunction / Craniomandibular Disorders  \$50 per visit, 100% thereafter No Deductible  \$60%  60%  60%	Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.		60%
Therapy Services (Cardiac Rehab, Chemotherapy, Radiation Therapy and Dialysis)  Temporomandibular Joint Dysfunction / Craniomandibular Disorders  80%  60%	Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.		60%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders  80% 60%	Therapy Services (Cardiac Rehab, Chemotherapy, Radiation	80%	60%
·	Temporomandibular Joint Dysfunction / Craniomandibular	80%	60%
		000/ -4	ul. Da divetible

PHYSICIAN SERVICES (continued)		
	NETWORK <sup>2</sup>	NON-NETWORK <sup>2</sup>
Advanced Diagnostic Imaging Services (MRI, CT, PET, etc.) Maximum one Co-Pay per service.	\$150 Co-Pay per type of service per day, 80% thereafter, No Deductible	60%
Basic Diagnostic Services (standard imaging, diagnostic medical, ab/pathology) Maximum one Co-Pay per service.	\$25 Co-Pay per type of service per day, 80% thereafter, No Deductible	60%
Allergy Testing and Treatment	80%	60%
INPATIENT HOSPITA	L / FACILITY SERVICES	
Unlimited Days Semi-Private Room and Board		
Note: If an admission is not Precertified, you will pay a \$500 Precertification review penalty. Per admission Co-Pay does not apply to Deductible or Coinsurance limits.	\$500 per admission Co-Pay, 80% thereafter	\$500 per admission Co-Pay. 60% thereafter
Ancillaries, Drugs, Therapy Services, X-ray and Lab	80%	60%
General Nursing Care	80%	60%
Surgical Services	80%	60%
[Birthing Center Care/Maternity Services - Dependent daughters are covered. Per admission Co-Pay does not apply to Deductible or Coinsurance limits. (Covered only when purchasing the Maternity rider.)]	[\$500 per admission Co-Pay, 80% thereafter] [No Benefits]	[\$500 per admission Co-Pay. 60% thereafter] [No Benefits]
OUTPATIENT HOSPITA	AL / FACILITY SERVICES	
Pre-Admission Testing	80%	60%
Advanced Diagnostic Imaging Services (MRI, CT, PET, etc.) Maximum one Co-Pay per service.	\$150 Co-Pay per type of service per day, 80% thereafter, No Deductible	60%
Basic Diagnostic Services (standard imaging, diagnostic medical, ab/pathology) Maximum one Co-Pay per service.	\$25 Co-Pay per type of service per day, 80% thereafter, No Deductible	60%
Surgery, Operating Room	80%	60%
Radiation and Chemotherapy	80%	60%
Physical Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.	\$50 per visit, 100% thereafter, No Deductible	60%
Occupational Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.	\$50 per visit, 100% thereafter, No Deductible	60%
Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services Combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. 10 visit Maximum per Calendar year.	\$50 per visit, 100% thereafter, No Deductible	60%
<b>Therapy Services</b> (Cardiac Rehab, Chemotherapy, Radiation Therapy and Dialysis)	80%	60%
Respiratory, Hyperbaric and Pulmonary Therapy	80% after Netwo	ork Deductible
BEHAVIORAL H	EALTH SERVICES	
Outpatient Mental Health Services	No Benefits	No Benefits
Outpatient Substance Abuse Services	No Benefits No Benefits	
npatient Mental Health Care Services	No Benefits	No Benefits
npatient Substance Abuse Care Services	No Benefits	No Benefits

EMERGENCY CARE SERVICES		
	NETWORK <sup>2</sup>	NON-NETWORK <sup>2</sup>
Emergency Accident Care and / or Emergency Medical Care provided in the ER	\$150 per visit (waived if admitted), 100% thereafter, No Deductible	
ER Co-Pay does not apply to Deductible or Coinsurance limits.		
Emergency Ambulance	80% after Network Deductible	
NON-EMERGENC	Y CARE SERVICES	
Non-Emergency Medical Care provided in the ER	\$150 per visit (waived if admitted) 80% after deductible	\$150 per visit (waived if admitted) 60% after deductible
Non-Emergency Ambulance Services	80% after Network Deductible	
OTHER COVE	RED SERVICES	
Private Duty Nursing – (240 hours Maximum per Calendar year) Note: Maximums are Network and Non-Network combined.	80% after Network Deductible	
Skilled Nursing Facility- Note: If admission is not Precertified, you pay a \$500 Precertification review penalty.	\$500 per admission Co-Pay, 80% thereafter	\$500 per admission Co-Pay, 60%, Maximum 100 days per Calendar year
Durable Medical Equipment and Oxygen at home	80%	60%
Orthotic Devices and Prosthetic Appliances	80%	60%
Home Infusion Therapy	80% after Network Deductible	
Home Health Care	80%	60%
Hospice Care	Inpatient: \$500 per admission Co-Pay, 80% thereafter Outpatient: 80%	Inpatient: \$500 per admission Co-Pay, 60% thereafter Outpatient: 60%
HUMAN ORGAN TRANSPLANT	<b>/ BONE MARROW PROCE</b>	DURES
Human Organ Transplant • \$150 per day to a maximum of \$10,000 for transportation, meals and lodging	Inpatient: \$500 per admission Co-Pay, 80% thereafter Outpatient: 80%	Inpatient: \$500 per admission Co-Pay, 60% thereafter Outpatient: 60%
Bone Marrow Procedures • \$150 per day to a maximum of \$10,000 for transportation, meals and lodging.	Inpatient: \$500 per admission Co-Pay, 80% thereafter Outpatient: 80%	Inpatient: \$500 per admission Co-Pay, 60% thereafter Outpatient: 60%

Eligible Dependent Age Limitation	Coverage stops at the end of the month of the 26 <sup>th</sup> birthday for an adult Dependent who qualifies as an Eligible Dependent.
Precertification Requirement	Penalty for no Precertification is a \$500 reduction of benefits per Inpatient admission.
Preexisting Condition Limitation (Note: For plan years beginning on or after September 23 <sup>rd</sup> , 2010, preexisting condition limitation does not apply to children under 19 years of age.)	Preexisting Condition Waiting Period: If you were enrolled in another health group health insurance policy prior to the effective date of your coverage under this Contract, the length of time you were covered under the previous policy will be applied to reduce the Preexisting Condition Waiting Period. If there is a 63 day lapse in coverage, the 365 day Waiting Period will apply."

<sup>&</sup>lt;sup>1</sup>ALL SERVICES ARE SUBJECT TO A DETERMINATION OF MEDICAL NECESSITY BY HIGHMARK WV.

<sup>&</sup>lt;sup>2</sup>PAYMENT IS BASED ON THE PLAN ALLOWANCE. THE PLAN ALLOWANCE WILL GENERALLY BE LESS FOR SERVICES RECEIVED FROM A NON-NETWORK PROVIDER. IN ADDITION, YOU WILL BE RESPONSIBLE FOR THE NON-NETWORK LIABILITY.

<sup>&</sup>lt;sup>3</sup>THE SCHEDULE OF COVERED SERVICES IS BASED UPON RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS; THE AMERICAN COLLEGE OF PHYSICIANS; THE U.S. PREVENTIVE SERVICES TASK FORCE; THE AMERICAN CANCER SOCIETY AND THE BLUE CROSS BLUE SHIELD ASSOCIATION. THEREFORE, THE FREQUENCY AND ELIGIBILITY OF SERVICES IS SUBJECT TO CHANGE.