

CEBCO Plan 3D
Blue AccessSM (PPO)
Summary of Benefits

Effective 01/01/2017

| Covered Benefits | Network | Non-Network |
|--|---|--|
| Deductible (Single/Family) | \$1,200/\$2,400 | \$3,000/\$6,000 |
| Out-of-Pocket Limit (Single/Family) | \$3,500/\$7,000 | \$7,000/\$14,000 |
| Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) allergy testing routine and non-routine mammograms (regardless of outpatient setting) diabetic education (regardless of outpatient setting) certain medical nutritional therapy (regardless of outpatient setting) MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds | \$25/\$50 25% No copayment/coinsurance No copayment/coinsurance No copayment/coinsurance 25% | 50% 50% 50% 50% Not Covered 50% |
| Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations ¹ , Annual diabetic eye exam, Routine Vision and Hearing exams <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility | No copayment/coinsurance No copayment/coinsurance | 50% 50% |
| Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted) Urgent Care Center Services | \$250 \$50 | \$250 \$50 |
| Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams | 25% | 50% |
| Inpatient Facility Services Unlimited days except for: <ul style="list-style-type: none"> 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 90 days Network/Non-Network combined for skilled nursing facility | 25% | 50% |
| Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia | 25% | 50% |
| Other Outpatient Services (including but not limited to): <ul style="list-style-type: none"> Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) Durable Medical Equipment, Orthotics and Prosthetics Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services | 25% 25% 25% 25% 25% | 50% 50% 50% 25% 25% |

| Covered Benefits | Network | Non-Network |
|---|-----------------------------|-----------------------------|
| Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical therapy: 30 visits Occupational therapy: 30 visits Manipulation therapy: 12 visits Speech therapy: 20 visits | \$25/\$50 25% | 50% 50% |
| Behavioral Health Services: Mental Health and Substance Abuse² <ul style="list-style-type: none"> Inpatient Facility Services Inpatient Professional Services Physician Home and Office Visits Other Outpatient Services @ Hospital/Alternative Care Facility | 25% 25% \$25 25% | 50% 50% 50% 50% |
| Human Organ and Tissue Transplants³ <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. | No copayment/coinsurance | 50% |
| Prescription Drugs | Covered under separate plan | Covered under separate plan |

Notes:

- All medical deductibles, copayments and coinsurance apply toward the out-of-pocket (excluding Prescription Drug cost share options and Non-network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan. SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Benefit period = calendar year
- Private Duty Nursing-limited to 82 visits/calendar year and 164 visits/lifetime

¹These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

²We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

³Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

Precertification:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period: None

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

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| Authorized group signature (if applicable) | Date |
| Underwriting signature (if applicable) | Date |