

# PPOBlue

Description of Service	Network		Out-of-network	
	PPOBlue pays	You pay <sup>2</sup>	PPOBlue pays	You pay <sup>2</sup>
Lifetime benefits	Unlimited		Unlimited	
Office visits	90%	10%	70%	30%
Diagnostic services	90%	10%	70%	30%
Ambulance service	90%	10%	70%	30%
Emergency care	90%	10%	90%	10%
Inpatient hospital services	90%	10%	70% (Limited to 90 days per benefit period)	30% (100% after 90-day covered period)
Inpatient and outpatient surgery and medical services	90%	10%	70%	30%
Prescription drugs <sup>5</sup>	90%	10%	Not covered	100%
Preventive medications <sup>4, 5</sup>	100% Deductible does not apply	0%	Not covered	100%
Maternity services	90%	10%	70%	30%
Therapy and rehabilitation services <sup>6</sup>	90%	10%	70%	30%
<b>Spinal manipulations</b> 10 visits per contract year combined in and out-of-network	90%	10%	70%	30%
Allergy extracts/injections	90%	10%	70%	30%
<b>Preventive care.<sup>8</sup> Annual deductible does not apply to services listed below</b>				
Routine annual physical exam	100%	0%	Not covered	100%
Routine annual gynecological exam and Pap smear	100%	0%	Not covered	100%
<b>Immunizations</b> Adult and pediatric	100%	0%	Not covered	100%
Mammographic screenings	100%	0%	Not covered	100%
<b>Routine eye exams</b> every 24 months	Not covered	100%	Not covered	100%
<b>Individual (1 member per agreement)</b>				
Deductible—individual		Choice of: \$1,200; \$2,600; \$3,500		Choice of network deductible includes out-of-network benefits
Out-of-pocket limit—individual		\$1,000; \$1,200; \$1,500		\$2,000; \$2,400; \$3,000
<b>Family (2 or more family members per agreement)</b>				
Deductible—family <sup>10</sup>		Choice of: \$2,400; \$5,200; \$7,000		Choice of network deductible includes out-of-network benefits
Out-of-pocket limit—family		\$2,000; \$2,400; \$3,000		\$4,000; \$4,800; \$6,000