SCHOOLCARE Blue Open Access *(phasing out 6/30/17)*

$10 Office Visit, $5/$15/$35 Rx

(Formerly POS)

SUMMARY OF BENEFITS

Benefits outlined below are intended only as a general summary. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this summary and the actual provisions of the plan, the provisions as defined in the Health Benefits Booklet, Amendments, and Riders will govern. Covered benefits are subject to review for medical necessity. Out of network payments to providers are based on reasonable and customary charges. Subscriber is responsible for charges above reasonable and customary. Plan year is defined from July 1 through June 30.

BENEFITS	BLUE OPEN ACCESS (In Network)	BLUE OPEN ACCESS (Out of Network)
DEDUCTIBLES, MAXIMUMS Plan Year Deductible Coinsurance Out-of-Pocket Maximum/Plan Year (Medical) Out-of-Pocket Maximum/Plan Year (Prescription Drugs) Maximum Lifetime benefit All copays and coinsurance contribute to the Out-of-Pocket Maximums.	PLAN MEMBER PAYS $0 20% (DME and EPA only) Individual: $1,000; Family: $2,000 Individual: $2,000; Family: $4,000 Unlimited	PLAN MEMBER PAYS Individual: $300; Family: $600 20% Individual: $900; Family: $1,800 Not Covered Unlimited
PREVENTIVE CARE* Routine Physical Examination Routine Immunizations Well Child Preventive Care Well Woman Preventive Care Adult Preventive Care Additional services such as urinalysis and EKG * Includes Naturopathic Services, Routine Laboratory and Diagnostic Testing	 $0 $0 $0 $0 $0 $0	 Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
ROUTINE VISION CARE Routine Exam (one every 12 months for all ages) Discounts Available for Eyewear	$10 per visit	Not Covered
HEARING TESTS	$10 per visit	Not Covered
OTHER PHYSICIAN SERVICES* Office Visits and/or Office Surgery Maternity Care * Includes Naturopathic Services (In-Network only)	 $10 per visit $10 per visit (initial visit only)	 Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
OUTPATIENT DIAGNOSTIC TESTING Radiology and Laboratory Services	$0 (Prior authorization required for some tests)	Deductible, then 20% to the Out of Pocket Maximum (Prior authorization required for some tests)
HOSPITAL CARE Inpatient Services Same Day or Outpatient Surgery Radiation and Chemotherapy Physician Visits and Services Anesthesiologist Services Operating Room X-Ray and Laboratory Services Medications and Supplies Newborn Care	$0 (Inpatient admissions and some outpatient procedures require prior authorization)	Deductible, then 20% to the Out of Pocket Maximum (Inpatient admissions and some outpatient procedures require prior authorization)

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BENEFITS	BLUE OPEN ACCESS (In Network)	BLUE OPEN ACCESS (Out of Network)
EMERGENCY & URGENT CARE *(Medically Necessary and Worldwide)*	PLAN MEMBER PAYS	PLAN MEMBER PAYS
Hospital Emergency Room	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)
Urgent Care Facility	$25 per visit (waived if admitted)	$25 per visit (waived if admitted)
MENTAL HEALTH/SUBSTANCE ABUSE		
OUTPATIENT (Physician's office)	$10 copay per visit	Deductible, then 20% to the Out of Pocket Maximum
INPATIENT HOSPITALIZATION AND OUTPATIENT FACILITY (Prior authorization required)	$0	Deductible, then 20% to the Out of Pocket Maximum
PRESCRIPTION DRUGS		
Through participating pharmacies	Retail: (30 day supply) $5 generic/$15 preferred brand name/$35 non-preferred brand name drugs.	Through participating pharmacies. See previous column.
Oral contraceptives (generic) covered at $0 copay	Maintenance: (90 day supply) $5 generic/$15 preferred brand name/$35 non-preferred brand name drugs available only	
(Prior authorization required for some drugs)		
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES		
OUTPATIENT: short-term rehab, up to 60 days per person/per plan year; includes PT, OT, ST and cardiac rehab (Combined maximum in and out of network)	$10 per day	Deductible, then 20% to the Out of Pocket Maximum
INPATIENT (Prior authorization required)	$0	Deductible, then 20% to the Out of Pocket Maximum
CHIROPRACTIC CARE		
20 days per person/per plan year (Combined maximum in and out of network)	$10 per day	Deductible, then 20% to the Out of Pocket Maximum
ACUPUNCTURE*		
12 days per person/per plan year (Combined maximum in and out of network)	$10 per day	$10 per day
Coverage based on Cigna's medical guidelines.		
DURABLE MEDICAL EQUIPMENT (DME)	20%	Deductible, then 20% to the Out of Pocket Maximum
EXTERNAL PROSTHETIC APPLIANCES (EPA)	20%	Deductible, then 20% to the Out of Pocket Maximum
OTHER BENEFITS		
ORAL SURGERY *(accidents only)*	$0 ($10, Physician's office)	All other covered services subject to plan year deductible and 20% coinsurance to the out-of-pocket maximum for the plan year.
REMOVAL OF BONEY IMPACTED WISDOM TEETH	$0 ($10, Physician's office)	
SKILLED NURSING CARE *(100 days maximum per person/per plan year)*	$0	(Exception: Ambulance service treated at in-network level)
AMBULANCE *(if not a true emergency, services are not covered)*	$0	
BLOOD TRANSFUSIONS	$0	
HOME HEALTH SERVICES	$0	
HOSPICE	$0	
GOOD FOR YOU! by SCHOOLCARE		
Health and Wellness Incentives, Employee Assistance Program	Included	Included