



A SUMMARY OF BLUE CARE® BENEFITS FOR WILMINGTON UNIVERSITY

SERVICE	BLUE CARE® IPA HMO
<p>PREVENTIVE MEDICAL SERVICES</p> <ul style="list-style-type: none"> ■ Periodic Physical Exams ■ Routine Annual GYN Exam ■ Routine Mammogram ■ Routine Sigmoidoscopy & Colonoscopy ■ Routine Pap Smear (<i>Lab charges</i>) ■ Routine Well-Child Care ■ Immunizations ■ Periodic Vision Exams ■ Periodic Hearing Exams ■ Prostate Screening Antigen Test (<i>Lab charges</i>) ■ Lead Poisoning Screening Test (<i>Lab charges</i>) 	<p>100% covered</p> <p>100% covered with PCP \$15.00 per visit with Ob/Gyn</p> <p>100% covered</p> <p>100% covered</p> <p>100% covered</p> <p>100% covered</p> <p>100% covered</p> <p>\$15.00 per visit</p> <p>\$5.00 per visit to PCP</p> <p>100% covered</p> <p>100% covered</p>
<p>TREATMENT OF ILLNESS OR INJURY</p> <ul style="list-style-type: none"> ■ Doctor's Office Visit for Diagnosis & Treatment ■ Specialist/Referral Care ■ Allergy Testing ■ Allergy Treatment ■ Laboratory Services ■ Imaging & Machine Testing Services ■ Physical & Occupational Therapy ■ Speech Therapy ■ Radiation Therapy & Chemotherapy ■ Home/Nursing Home Visits ■ Chiropractic 	<p>\$5.00 per visit</p> <p>\$15.00 per visit</p> <p>\$5.00 per visit</p> <p>\$5.00 per visit</p> <p>100% covered</p> <p>100% covered</p> <p>80% covered for up to 30 combined visits per calendar year</p> <p>80% covered for up to 30 visits per calendar year</p> <p>100% covered.</p> <p>\$25.00 per visit.</p> <p>\$15.00 per visit for up to 30 visits per calendar year.</p>
<p>IN THE HOSPITAL^{1,2}</p> <ul style="list-style-type: none"> ■ Semiprivate Room & Board (including intensive care, if medically appropriate) ■ Physician's & Surgeon's Services ■ Other Medical Professional Services 	<p>\$100 per day for five days (calendar year maximum of \$500 per person; \$1,000 per family), then covered at 100%.^{1,2}</p> <p>100% covered.^{1,2}</p> <p>100% covered.^{1,2}</p>

**A SUMMARY OF BLUE CARE® BENEFITS
FOR WILMINGTON UNIVERSITY (CONTINUED)**

SERVICE	BLUE CARE® IPA HMO
SURGERY^{1,2} ■ Outpatient	100% covered (except sterilization which is \$25.00 per procedure). ^{1,2}
MATERNITY ■ Prenatal & Postnatal Care ■ Delivery: Hospital ■ Delivery: Physician ■ Birthing Center	100% covered. 100% covered. 100% covered. 100% covered.
EMERGENCY SERVICES ■ Physician's Office ■ Hospital ■ Outpatient Emergency Facilities	\$5.00 per visit. \$100.00 per visit (waived if admitted). \$100.00 per visit (waived if admitted).
AMBULANCE	\$25.00 per occurrence.
OTHER SERVICES ■ Inpatient Private Duty Nursing ■ Prosthetic Devices and Durable Medical Equipment ■ Skilled Nursing Facility ■ Home Health Care	100% covered for up to 240 hours per 12-month period. 80% covered. 100% covered for up to 120 days per confinement. 100% covered for up to 100 visits per calendar year.
ALCOHOL AND DRUG ABUSE TREATMENT	Authorized: Same as Other Medical Care. Non-Authorized: Not Covered.
SERIOUS MENTAL HEALTH CARE ■ Inpatient and Partial Hospitalization ■ Outpatient	Same as Other Medical Care. Same as Other Medical Care.
OTHER MENTAL HEALTH CARE ■ Inpatient and Partial Hospitalization ■ Outpatient	Authorized: Same as Other Medical Care. Non-Authorized: Not Covered. \$15.00 per visit

A SUMMARY OF BLUE CARE[®] BENEFITS FOR WILMINGTON UNIVERSITY (CONTINUED)

PRESCRIPTION DRUGS³ (Per Prescription or Refill)	
<ul style="list-style-type: none"> ■ Retail, for 34-Day Supply <ul style="list-style-type: none"> ▪ Generic ▪ Preferred Brand ▪ Non-Preferred Brand ■ Mail Order, for 90-Day Supply <ul style="list-style-type: none"> ▪ Generic ▪ Preferred Brand ▪ Non-Preferred Brand 	<ul style="list-style-type: none"> \$ 10.00 Copayment.³ \$ 25.00 Copayment.³ \$ 50.00 Copayment.³ \$ 20.00 Copayment.³ \$ 50.00 Copayment.³ \$ 100.00 Copayment.³

Blue Care Members: All services must be provided or approved in advance by the primary care physician.

- ¹ Facility charges and professional services for transplants performed at Blue Distinction Centers for Transplants[®] (BDCT) facilities are covered at the in-network facility benefit level. For transplants performed at participating but non-BDCT facilities, charges are covered at a 20 percentage point reduction off the BDCT level. In the absence of a plan year coinsurance expense limit, member coinsurance associated with the benefit reduction is capped at \$10,000 per transplant. Transplants performed at non-participating facilities are not covered. Other limits apply.
- ² Facility charges and professional services for bariatric surgeries are subject to any in-network copay or deductible, then are covered at 50%. Coinsurance does not apply to any coinsurance expense limit. Member must meet eligibility criteria to qualify for surgery.
- ³ If an individual chooses a Preferred or Non-Preferred Brand drug when a Generic drug is available, he or she will have to pay the difference between the charge for the Preferred or Non-Preferred Brand drug and the Generic drug, plus the copay for the Generic Drug.

All percentages listed above apply to Blue Cross Blue Shield of Delaware's maximum allowable charge.

When calculating deductible or coinsurance expenses, only the allowable charges are considered.

This is not a contract. This benefits comparison is intended to provide you with a general overview of these Blue Cross Blue Shield of Delaware health benefit programs.

Blue Cross Blue Shield of Delaware is an independent licensee of the Blue Cross and Blue Shield Association.