Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

Furnished by a facility that is primarily a place of treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.

For Acute Care, rehabilitative care, diagnostic testing, evaluation, or Treatment of Mental or Nervous Conditions, Substance Abuse or Addiction, or for Pain Rehabilitation, except as specified as a Covered Service in the Policy.

Incurred by an unenrolled Eligible Dependent child or care of treatment of any condition arising from or related to pregnancy, childbirth, delivery, or an Involuntary Complication of Pregnancy, unless specified as a Covered Service in the Policy.

For weight control or treatment of obesity or mental obscurity, including but not limited to Surgery for obesity, except when Surgery for obesity is Medical Necessity to control other medical conditions that are eligible for Covered Services under the Policy, and nonsurgical methods have been unsuccessful in treating the obesity, for revisions or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition.

For an obstetric abortion to terminate the life of the fetus where the abortion is performed.

For the use of operating, cast, examination, or treatment rooms or for equipment located in a Contracting or Noncontracting Provider's office or facility, except for emergency care or care furnished in a licensed General Hospital, unless specified as a Covered Service in the Policy.

For the reversal of striae formation procedures, including but not limited to, laser treatments, subcutaneous injections, etc.

Treatment for infertility and fertility procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization procedures, transfer or similar procedures, or that any way augment or enhance an Insured's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for fertility or fertility procedures.

For Transport Services and Artificial Organs, except as specified as a Covered Service in the Policy.

For TPS procedures.

For Chiropractic Care, except as specified as a Covered Service in the Policy.

For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, transverse keratotomy, laser in situ keratomileusis (LASIK), and other surgical procedures of the refractive keratoplasty type, to correct or reduce myopia or astigmatism, even if medically Necessary. Additional: implants, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

For Hospice Home Care, except as specified as a Covered Service in the Policy.

For specialized, spiritual, bereavement, family and/or marriage counseling.

For homeowner's and housekeeping services or home delivered meals.

For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal or excessive, or unless such injuries are a result of a medical condition or condition of violence.

For any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under the Policy or for any similar coverage, or for which no charge or a different charge is usually made in the absence of insurance coverage.

For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury. That any examination required on account of employment, or related to an occupational injury, for a marriage license, or for insurance, school or camp applications, or for sports participation physical, or a screening examination including routine hearing examinations, except as specified as a Covered Service in the Policy.

For remunerations, except as specified as a Covered Service in the Policy.

For laser reduction Surgery or Surgery for glaucoma.

For nutritional supplements.

For replacements or nutritional formulas except, when administered ordinarily due to impairment in digestion and absorption of an oral diet and is the sole source of calories required for the Insured.

For vitamins and minerals, unless required through a prescription and cannot be purchased over the counter.

For alterations or modifications to a home or vehicle.

For special clothing, including (shoes) merely permanently attached to a brace).

Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

Provided outside the United States, which if not provided in the United States, would be covered as a Covered Service under the Policy.

Furnished by a Provider or caregiver that is not listed as a Covered Provider, including but not limited to, pain management and home health.

For Outpatient pulmonary and/or cardiac rehabilitation.

For complications arising from the acceptance or utilization of noncovered services.

For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service in the Policy.

For wigs and walking aid (cane, crutches, or walker).

For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to, plastic surgery procedures for weight reduction (obesity) Surgery.

For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.
## Options and Benefits

### Deductible Choices
- **BlueCare PPO 1000:**
  - In-network: $1,000 per person - $2,000 per family aggregate*
  - Out-of-network: $2,000 per person - $4,000 per family aggregate*
- **BlueCare PPO 2000:**
  - In-network: $3,000 per person for in-network services
  - Out-of-network: $4,000 per person for in-network services
  - In-network: $4,000 per person for out-of-network services
  - Out-of-network: $7,000 per person for out-of-network services
- **BlueCare PPO 5000:**
  - In-network: $5,000 per person - $10,000 per family aggregate*

### Coinsurance
- You pay 20% of the allowed amount for covered services from non-contracting providers.
- You pay 50% of the allowed amount for covered services from contracting providers.

### Out-of-Pocket Maximum
- **BlueCare PPO 1000:**
  - Deductible is $0 per person for in-network services.
  - Deductible is $1,250 per person for out-of-network services.
- **BlueCare PPO 2000:**
  - Deductible is $0 per person for in-network services.
  - Deductible is $2,500 per person for out-of-network services.
- **BlueCare PPO 5000:**
  - Deductible is $0 per person for in-network services.
  - Deductible is $5,000 per person for out-of-network services.

### Prescription Drugs
- You pay 50% of the allowed amount for covered services after meeting your deductible.
- You pay $3 copayment for specific drug benefits in BlueCare PPO 1000.
- You pay $5 copayment for specific drug benefits in BlueCare PPO 2000.
- You pay $7 copayment for specific drug benefits in BlueCare PPO 5000.

### Physician Office Visits
- You pay $25 copayment.
- You may not pay for specifically listed services.

### Preventive Care Benefits
- You pay 100% of the allowed amount for listed services.
- You pay nothing for specifically listed services.

### Diabetes Self-Management Education Services
- You pay 100% of the allowed amount for listed services.

### Allergy Injections
- You pay $5 copayment per injection.

### Inpatient Psychiatric Services
- You pay 50% of the allowed amount for listed services.

### Inpatient Physical Rehabilitation Services
- You pay 50% of the allowed amount for listed services.

### Radiation Therapy Services
- You pay 50% of the allowed amount for listed services.
- You pay $5 copayment per injection.

### Home Intravenous Therapy
- You pay 50% of the allowed amount for listed services.

### Dental Services Related to Accidental Injury
- You pay 50% of the allowed amount for listed services.

### Annual Maximum Benefit Limit
- You pay nothing for specific drug benefits for in-network services.
- You pay $75 copayment for specific drug benefits.

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* One family member cannot contribute more than their individual deductible amount toward the total family deductible.

** Blue Distinction Centers for Transplants (BDCTs) are major hospitals and treatment facilities found throughout the United States that are affiliated with the Blue Cross Blue Shield Association.

The options and benefits listed above are provided for general information purposes only; they are intended to give you a summary of the plan’s benefits. Upon joining, you will receive a copy of the policy and an outline of coverage, which will provide further information on benefits, limitations and exclusions that are not described in this summary.