

Type of Care/Plan Benefits	Coverage
<p>Plan features</p> <ul style="list-style-type: none"> · Primary Care Physician (PCP) · Referrals · Out of network benefits · Out of area benefits · Student/Dependent coverage · Domestic partner <p>Plan cost-sharing highlights</p> <ul style="list-style-type: none"> · Office visit copay (Primary Care Physician) · Office visit copay (Specialist) · Coinsurance · Deductible · Out of pocket maximum - Medical · Lifetime maximum · Prescription Drug - out-of pocket copayment maximum 	<ul style="list-style-type: none"> · No copay, office visit covered subject to deductible and coinsurance · Not required · Covered · Coverage provided worldwide through the BlueCard program. · Qualified dependents and students are covered to age 26. · Not covered <ul style="list-style-type: none"> · No copay, office visit covered subject to deductible and coinsurance · No copay, office visit covered subject to deductible and coinsurance · 20%, enhanced benefits only, unless noted · \$1,000 individual / \$3,000 family, enhanced benefits only · \$1,000 individual / \$3,000 family, enhanced benefits only · None · \$2,000 Individual / \$6,000 Family

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<p>Wellness Incentive</p> <ul style="list-style-type: none"> · Stay healthy with great programs and incentives! <p>Preventive Health Care Services</p> <ul style="list-style-type: none"> · Well child visits · Adult routine physical exams · Adult immunizations · Mammography · Pap smear · Routine GYN exam · Prostate cancer screening · Routine vision · Colonoscopy <p>Physician Office Services</p> <ul style="list-style-type: none"> · Diagnostic office visits · Diagnostic x-rays · Diagnostic laboratory and pathology · Allergy tests · Allergy injections · Chemotherapy · Radiation therapy <p>Maternity Services</p> <ul style="list-style-type: none"> · Prenatal and postpartum care · Hospital care for mom (including delivery) · Newborn nursery care 	<ul style="list-style-type: none"> · Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids. <ul style="list-style-type: none"> · Covered in full · Covered in full for 1 exam per year · Covered in full · Covered in full · Covered in full · Covered in full · Covered in full · Covered in full · Not covered · Covered in full <ul style="list-style-type: none"> · Subject to deductible and coinsurance · Covered in full · Covered in full · Subject to deductible and coinsurance · Subject to deductible and coinsurance · Covered in full · Covered in full <ul style="list-style-type: none"> · Covered in full · Covered in full · Covered in full

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<p>Prescription Drug</p> <ul style="list-style-type: none"> Short-term and maintenance drugs are covered up to a 30-day supply at participating retail pharmacies; 90-day supply is available through Express Scripts and Wegmans Home Delivery pharmacy. Contraceptives included. 	<ul style="list-style-type: none"> \$.10/\$.25/\$.40
<p>Inpatient Hospital Benefits</p> <ul style="list-style-type: none"> Hospital benefits Physician visits in the hospital Inpatient physical rehabilitation deductible Surgery Anesthesia 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full, limited to 30 days per year. Subject to no and coinsurance after basic benefits have exhausted for unlimited days Covered in full Covered in full
<p>Emergency Care</p> <ul style="list-style-type: none"> Emergency room care Freestanding urgent care center Ambulance 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full
<p>Outpatient Hospital Benefits</p> <ul style="list-style-type: none"> Diagnostic x-rays Diagnostic laboratory and pathology Surgical care Chemotherapy Radiation therapy 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full Covered in full Covered in full
<p>Mental Health and Chemical Dependence</p> <ul style="list-style-type: none"> Inpatient mental health care Outpatient mental health care Inpatient chemical dependence Outpatient chemical dependence 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full Covered in full
<p>Other Services</p> <ul style="list-style-type: none"> Diabetic insulin and supplies Skilled nursing facility Home care and Hospice Outpatient therapy Durable medical equipment External prosthetics Chiropractic Acupuncture Dental Hearing 	<ul style="list-style-type: none"> 20% coinsurance , enhanced benefit Covered in full, limited to 100 days per year. Subject to no deductible and coinsurance after basic benefits have exhausted for unlimited days Covered in full for up to 60 visits per year. Subject to deductible coinsurance after basic benefits have exhausted for up to 325 visits per year Covered in full Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Not covered Not Covered Not covered

Please Note: This is an outline of benefits only. Official benefits and conditions of coverage are outlined in your member certificate. Benefit questions should be directed to Customer Service at 1-800-499-1275.

Professional Non-participating Provider In-area covered at 100% of current Medicare National rates; Out-of-area covered at 150% of current Medicare National rates. Facility Non-participating covered at 80% of charge. The following services require preauthorization: organ transplants, non-mandated reproductive procedures (IVF, GIFT & ZIFT).