

| Type of Care/Plan Benefits  | Coverage  |
|---|---|
| <p><b>Plan features</b></p> <ul style="list-style-type: none"> <li>· Primary Care Physician (PCP)</li> <li>· Referrals</li> <li>· Out of network benefits</li> <li>· Out of area benefits</li> <li>· Student/Dependent coverage</li> <li>· Domestic partner</li> </ul> <p><b>Plan cost-sharing highlights</b></p> <ul style="list-style-type: none"> <li>· Office visit copay (Primary Care Physician)</li> <li>· Office visit copay (Specialist)</li> <li>· Coinsurance</li> <li>· Deductible</li> <li>· Out of pocket maximum - Medical</li> <li>· Lifetime maximum</li> <li>· Prescription Drug - out-of pocket copayment maximum</li> </ul> | <ul style="list-style-type: none"> <li>· No copay, office visit covered subject to deductible and coinsurance</li> <li>· Not required</li> <li>· Covered</li> <li>· Coverage provided worldwide through the BlueCard program.</li> <li>· Qualified dependents and students are covered to age 26.</li> <li>· Not Covered</li> </ul><br><ul style="list-style-type: none"> <li>· No copay, office visit covered subject to deductible and coinsurance</li> <li>· No copay, office visit covered subject to deductible and coinsurance</li> <li>· 20%, enhanced benefits only, unless noted</li> <li>· \$500 individual / \$1,500 family, enhanced benefits only</li> <li>· \$1,000 individual / \$3,000 family, enhanced benefits only</li> <li>· None</li> <li>· Covered same as medical</li> </ul> |

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

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| <p><b>Prescription Drug</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>  | <ul style="list-style-type: none"> <li>Included under medical subject to deductible and coinsurance</li> </ul>  |
| <p><b>Inpatient Hospital Benefits</b></p> <ul style="list-style-type: none"> <li>Hospital benefits</li> <li>Physician visits in the hospital</li> <li>Inpatient physical rehabilitation deductible</li> <li>Surgery</li> <li>Anesthesia</li> </ul>  | <ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full, limited to 30 days per year. Subject to no and coinsurance after basic benefits have exhausted for unlimited days</li> <li>Covered in full</li> <li>Covered in full</li> </ul>  |
| <p><b>Emergency Care</b></p> <ul style="list-style-type: none"> <li>Emergency room care</li> <li>Freestanding urgent care center</li> <li>Ambulance</li> </ul>  | <ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> </ul>   |
| <p><b>Outpatient Hospital Benefits</b></p> <ul style="list-style-type: none"> <li>Diagnostic x-rays</li> <li>Diagnostic laboratory and pathology</li> <li>Surgical care</li> <li>Chemotherapy</li> <li>Radiation therapy</li> </ul>   | <ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> </ul>   |
| <p><b>Mental Health and Chemical Dependence</b></p> <ul style="list-style-type: none"> <li>Inpatient mental health care</li> <li>Outpatient mental health care</li> <li>Inpatient chemical dependence</li> <li>Outpatient chemical dependence</li> </ul>  | <ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> </ul>  |
| <p><b>Other Services</b></p> <ul style="list-style-type: none"> <li>Diabetic insulin and supplies</li> <li>Skilled nursing facility</li> <li>Home care and</li> <li>Hospice</li> <li>Outpatient therapy</li> <li>Durable medical equipment</li> <li>External prosthetics</li> <li>Chiropractic</li> <li>Acupuncture</li> <li>Dental</li> <li>Hearing</li> </ul> | <ul style="list-style-type: none"> <li>20% coinsurance , enhanced benefit</li> <li>Covered in full, limited to 100 days per year. Subject to no deductible and coinsurance after basic benefits have exhausted for unlimited days</li> <li>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</li> <li>Covered in full</li> <li>Subject to deductible and coinsurance</li> <li>Subject to deductible and coinsurance</li> <li>Subject to deductible and coinsurance</li> <li>Subject to deductible and coinsurance</li> <li>Not covered</li> <li>Not Covered</li> <li>Not covered</li> </ul> |

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).