

Type of Care/Plan Benefits	In-Network	Out Of Network
Plan features . Primary Care Physician (PCP) . Referrals . Out of network benefits . Out of area benefits . Student/Dependent coverage . Domestic partner . Coverage Period	<ul> <li>Not required</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>Covered</li> <li>January 1st - December 31st</li> </ul>	
Plan cost-sharing highlights     Office visit copay (Primary Care Physician)     Office visit copay (Specialist)     Coinsurance     Deductible     Out of pocket maximum     Lifetime maximum	<ul> <li>\$10 copay</li> <li>\$10 copay</li> <li>In-network: None; Out-of-network: 20%</li> <li>In-network: None Out of Network \$250 individual /\$750 family</li> <li>In-network: None; Out of Network \$1,000 individual /\$3,000 family</li> <li>None</li> </ul>	

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Wellness Incentive  Stay healthy with great programs and incentives!	Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids.	Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids.
Preventive Health Care Services . Well child visits . Adult routine physical exams	Covered in full Covered in full for 1 exam per year according to national guidelines	<ul> <li>Covered in full</li> <li>Covered at 80%, subject to the deductible for one routine exam per year</li> </ul>
. Adult immunizations . Mammography	Covered in full     Covered in full	<ul> <li>Not Covered</li> <li>Covered at 80%, subject to the deductible</li> </ul>
. Pap smear	• Covered in full	Covered at 80%, subject to the deductible
. Routine GYN exam	• Covered in full	Covered at 80%, subject to the deductible
Prostate cancer screening	• \$10 copay	Covered at 80%, subject to the deductible
. Routine vision	• \$10 copay for one routine exam every year; \$60 eyewear allowance available per year	<ul> <li>Covered at 80%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available</li> </ul>
. Colonoscopy	Preventive and diagnostic covered according to the surgical benefit	per year  Covered at 80%, subject to the deductible
<ul> <li>New York State women's preventative services mandate</li> </ul>	Covered effective 1/1/13	deductible

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Physician Office Services  Diagnostic office visits	• \$10 copay per visit	<ul> <li>Covered at 80%, subject to the</li> </ul>
. Diagnostic x-rays	• \$10 copay. Precertification applies for MRI, PET and CAT scans.	deductible Covered at 80%, subject to the deductible. Precertification applies to
<ul> <li>Diagnostic laboratory and pathology</li> </ul>	• Covered in full	MRI, PET and CAT scans.  Covered at 80%, subject to the deductible
. Allergy tests	• \$10 copay per visit	Covered at 80%, subject to the deductible
. Allergy injections	• Covered in full	Covered at 80%, subject to the deductible
. Chemotherapy	• Covered in full	Covered at 80%, subject to the deductible
. Radiation therapy	Covered in full	<ul> <li>Covered at 80%, subject to the deductible</li> </ul>
Matamitu Comicas		
Maternity Services . Prenatal Care	• Covered in full	Covered at 80%, subject to the
<ul><li>Hospital care for mom (including delivery)</li><li>Newborn nursery care</li></ul>	Hospital-Covered in full;     Delivery-Covered in full     Covered in full	<ul><li>deductible</li><li>Covered at 80%, subject to the deductible</li><li>Covered at 80%, subject to the deductible</li></ul>
Prescription Drug . Short-term and maintenance drugs	Not covered	Not covered
Inpatient Hospital Benefits . Hospital benefits	Covered in full for unlimited days.     Precertification applies.	<ul> <li>Covered at 80%, subject to the deductible. Precertification applies.</li> </ul>
. Physician visits in the hospital	Covered in full	Covered at 80%, subject to the deductible
. Inpatient physical rehabilitation	<ul> <li>Covered in full for up to 60 days per year. Precertification applies.</li> </ul>	<ul> <li>Covered at 80%, subject to the deductible for up to 60 days per year. Precertification applies.</li> </ul>
. Surgery	• Covered in full	Covered at 80%, subject to the deductible
. Anesthesia	Covered in full	<ul> <li>Covered at 80%, subject to the deductible</li> </ul>
Emergency Care . Emergency room care	• \$100 copay per visit, unless admitted	• \$100 copay per visit, unless admitted
Freestanding urgent care center	within 24 hours • \$25 copay per visit	within 24 hours • Covered at 80%, subject to the
. Ambulance	• Covered in full	deductible • Covered in full
Outpatient Hospital Benefits . Diagnostic x-rays	• \$10 copay per visit. Precertification applies for MRI, PET and CAT scans.	Covered at 80%, subject to the deductible. Precertification applies to
. Diagnostic laboratory and pathology	• Covered in full	<ul><li>MRI, PET and CAT scans</li><li>Covered at 80%, subject to the deductible</li></ul>

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. Surgical care	Covered in full	• Covered at 80%, subject to the
. Chemotherapy	Covered in full	deductible • Covered at 80%, subject to the
. Radiation therapy	• Covered in full	<ul><li>deductible</li><li>Covered at 80%, subject to the deductible</li></ul>
Mental Health and Chemical Dependence		
. Inpatient mental health care	<ul> <li>Covered in full for unlimited days.</li> <li>Precertification applies.</li> </ul>	<ul> <li>Covered at 80%, subject to the deductible. Precertification applies.</li> </ul>
. Outpatient mental health care	• \$10 copay. Services can be provided in an outpatient facility or in a provider office.	<ul> <li>Covered at 80%, subject to the deductible. Services can be provided in an outpatient facility or in a provider office.</li> </ul>
. Inpatient chemical dependence	<ul> <li>Covered in full for unlimited days.</li> <li>Precertification applies.</li> </ul>	<ul> <li>Covered at 80%, subject to the deductible. Precertification applies.</li> </ul>
. Outpatient chemical dependence	• \$10 copay per visit	Covered at 80%, subject to the deductible
Other Services . Diabetic insulin and supplies	• \$10 copay for up to a 30 day supply	<ul> <li>Covered at 80%, subject to the deductible for up to a 30 day supply</li> </ul>
. Skilled nursing facility	<ul> <li>Covered in full for up to 120 days per year. Precertification applies.</li> </ul>	<ul> <li>Covered at 80%, subject to the deductible for up to 120 days per year.</li> </ul>
. Home care	Covered in full for unlimited visits.  Precertification applies.	Precertification applies.  Covered at 80%, subject to a \$50 deductible for unlimited visits per year.  Precertification applies.
. Hospice	Covered in full for unlimited days	Covered at 80%, subject to the deductible for unlimited visits per year
. Outpatient therapy	\$10 copay per visit for up to a combined total of 45 visits per year for physical, speech, occupational and	<ul> <li>Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech,</li> </ul>
. Durable medical equipment	respiratory therapy • Covered at 80%. Precertification	occupational and respiratory therapy • Covered at 80%, subject to the
. External prosthetics	applies. • Covered at 80%	deductible. Precertification applies.  • Covered at 80%, subject to the
. Chiropractic	• \$10 copay per visit	deductible • Covered at 80%, subject to the
. Acupuncture	Covered at 50% for up to 10 visits per	deductible • Covered at 50%, subject to the
. Dental	year • \$10 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	<ul> <li>deductible, for up to 10 visits per year</li> <li>Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly</li> </ul>
<ul> <li>Hearing</li> <li>New York State autism spectrum disorder mandate</li> </ul>	<ul><li>Routine exams not covered</li><li>Covered effective 1/1/13</li></ul>	Routine exams not covered

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. These benefits should not be interpreted as pre-approval of services. Certain services may be subject to additional requirements described in the member's insurance policy. Payment of claims related to these benefits are subject to the member's eligibility on the date of service and the resolution of any other outstanding claims. The member is responsible for payment of a copay, deductible, coinsurance or any combination based on plan design. Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act may not be quoted herein. Please refer to the Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Protection and Affordable Care Act requirements. Benefits herein are subject to change as a result of efforts to implement federal health care reform and mental health and substance abuse care parity initiative. There may be additional coverage for biologically-based mental illness and for children with serious emotional disturbances as defined by Timothy's Law.