

Type of Care/Plan Benefits	In-Network	Out Of Network
<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 . Coverage Period <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 . Lifetime maximum 	<ul style="list-style-type: none"> . Not required . Not required . Covered . Coverage provided worldwide through the BlueCard program. . Qualified dependents and students are covered to age 26. . Covered . January 1st - December 31st <ul style="list-style-type: none"> . \$10 copay . \$10 copay . In-network: None; Out-of-network: 20% . In-network: None Out of Network \$250 individual /\$750 family . In-network: None; Out of Network \$1,000 individual /\$3,000 family . None 	

type of care/plan benefits	In-Network	Out Of Network
<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 . New York State women’s preventative services mandate 	<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. . Covered in full . Covered in full for 1 exam per year according to national guidelines . Covered in full . Covered in full . Covered in full . Covered in full . \$10 copay . \$10 copay for one routine exam every year; \$60 eyewear allowance available per year . Preventive and diagnostic covered according to the surgical benefit . Covered effective 1/1/13 	<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. . Covered in full . Covered at 80%, subject to the deductible for one routine exam per year . Not Covered . Covered at 80%, subject to the deductible . Covered at 80%, subject to the deductible . Covered at 80%, subject to the deductible . Covered at 80%, subject to the deductible . Covered at 80%, subject to the deductible . Covered at 80%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year . Covered at 80%, subject to the deductible

Type of Care/Plan Benefits	In-Network	Out Of Network
Physician Office Services <ul style="list-style-type: none"> • Diagnostic office visits • Diagnostic x-rays • Diagnostic laboratory and pathology • Allergy tests • Allergy injections • Chemotherapy • Radiation therapy 	<ul style="list-style-type: none"> • \$10 copay per visit • \$10 copay. Precertification applies for MRI, PET and CAT scans. • Covered in full • \$10 copay per visit • Covered in full • Covered in full • Covered in full 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible. Precertification applies to MRI, PET and CAT scans. • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible
Maternity Services <ul style="list-style-type: none"> • Prenatal Care • Hospital care for mom (including delivery) • Newborn nursery care 	<ul style="list-style-type: none"> • Covered in full • Hospital-Covered in full; Delivery-Covered in full • Covered in full 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible
Prescription Drug <ul style="list-style-type: none"> • Short-term and maintenance drugs 	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • Not covered
Inpatient Hospital Benefits <ul style="list-style-type: none"> • Hospital benefits • Physician visits in the hospital • Inpatient physical rehabilitation • Surgery • Anesthesia 	<ul style="list-style-type: none"> • Covered in full for unlimited days. Precertification applies. • Covered in full • Covered in full for up to 60 days per year. Precertification applies. • Covered in full • Covered in full 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible. Precertification applies. • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible for up to 60 days per year. Precertification applies. • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible
Emergency Care <ul style="list-style-type: none"> • Emergency room care • Freestanding urgent care center • Ambulance 	<ul style="list-style-type: none"> • \$100 copay per visit, unless admitted within 24 hours • \$25 copay per visit • Covered in full 	<ul style="list-style-type: none"> • \$100 copay per visit, unless admitted within 24 hours • Covered at 80%, subject to the deductible • Covered in full
Outpatient Hospital Benefits <ul style="list-style-type: none"> • Diagnostic x-rays • Diagnostic laboratory and pathology 	<ul style="list-style-type: none"> • \$10 copay per visit. Precertification applies for MRI, PET and CAT scans. • Covered in full 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible. Precertification applies to MRI, PET and CAT scans • Covered at 80%, subject to the deductible

Type of Care/Plan Benefits	In-Network	Out Of Network
<ul style="list-style-type: none"> • Surgical care • Chemotherapy • Radiation therapy 	<ul style="list-style-type: none"> • Covered in full • Covered in full • Covered in full 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible
<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 for unlimited days. Precertification applies. • \$10 copay. Services can be provided in an outpatient facility or in a provider office. • Covered in full for unlimited days. Precertification applies. • \$10 copay per visit 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible. Precertification applies. • Covered at 80%, subject to the deductible. Services can be provided in an outpatient facility or in a provider office. • Covered at 80%, subject to the deductible. Precertification applies. • Covered at 80%, subject to the deductible
<p>Other Services</p> <ul style="list-style-type: none"> • Diabetic insulin and supplies • Skilled nursing facility • Home care • Hospice • Outpatient therapy • Durable medical equipment • External prosthetics • Chiropractic • Acupuncture • Dental • Hearing • New York State autism spectrum disorder mandate 	<ul style="list-style-type: none"> • \$10 copay for up to a 30 day supply • Covered in full for up to 120 days per year. Precertification applies. • Covered in full for unlimited visits. Precertification applies. • Covered in full for unlimited days • \$10 copay per visit for up to a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy • Covered at 80%. Precertification applies. • Covered at 80% • \$10 copay per visit • Covered at 50% for up to 10 visits per year • \$10 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly • Routine exams not covered • Covered effective 1/1/13 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible for up to a 30 day supply • Covered at 80%, subject to the deductible for up to 120 days per year. Precertification applies. • Covered at 80%, subject to a \$50 deductible for unlimited visits per year. Precertification applies. • Covered at 80%, subject to the deductible for unlimited visits per year • Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy • Covered at 80%, subject to the deductible. Precertification applies. • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible • Covered at 50%, subject to the deductible, for up to 10 visits per year • Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly • 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.