



| 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• Lifetime 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• \$250 individual / \$750 family, enhanced benefits only• \$400 individual / \$1200 family, enhanced benefits only• None |

| Type of care/plan benefits | Coverage |
|--|--|
| <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 Care• Hospital care for mom (including delivery)• Newborn nursery care <p>Prescription Drug</p> <ul style="list-style-type: none">• Short-term and maintenance drugs | <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 the deductible and coinsurance• Covered in full• Covered in full <ul style="list-style-type: none">• Covered in full• Covered in full• Covered in full <ul style="list-style-type: none">• \$10/\$25/\$40 |

| Type of Care/Plan Benefits | Coverage |
|---|--|
| <p>Inpatient Hospital Benefits</p> <ul style="list-style-type: none"> • Hospital benefits • Physician visits in the hospital • Inpatient physical rehabilitation • Surgery • Anesthesia <p>Emergency Care</p> <ul style="list-style-type: none"> • Emergency room care • Freestanding urgent care center • Ambulance <p>Outpatient Hospital Benefits</p> <ul style="list-style-type: none"> • Diagnostic x-rays • Diagnostic laboratory and pathology • Surgical care • Chemotherapy • Radiation therapy <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 <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 | <ul style="list-style-type: none"> • Covered in full • Covered in full; day limits may apply • Covered in full. Limited to 30 days per year • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full -Day limits may apply • Covered in full • Covered in full- Day limits may apply • Covered in full for unlimited visits • Covered in full • Covered in full • Covered in full • Covered in full • Subject to deductible and 20% coinsurance • Subject to deductible and 20% coinsurance • Subject to deductible and 20% coinsurance • Subject to deductible and 20% coinsurance • Not Covered • Not covered 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.