

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. · 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 · \$100 individual / \$300 family, enhanced benefits only · \$400 individual / \$1200 family, enhanced benefits only · None · \$1,000 Individual / \$3,000

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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/\$20
<p>Inpatient Hospital Benefits</p> <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 • Covered in full • Covered in full, limited to 30 days per year. Subject to no deductible 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 Hospice Outpatient therapy Durable medical equipment External prosthetics Chiropractic Acupuncture Dental Hearing 	<ul style="list-style-type: none"> • \$10 copayment, 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 and 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).