

Type of Care/Plan Benefits	Coverage*
----------------------------	-----------

Plan features

- . Primary Care Physician (PCP)
- . Referrals
- . Out of network benefits
- . Out of area benefits
- . Student/Dependent coverage

Plan cost-sharing highlights

- . Office visit copay (Primary Care Physician)
- . Office visit copay (Specialist)
- . Coinsurance
- . Deductible
- . Out of pocket maximum
- . Lifetime maximum

- . Not required
- . Not required
- . Not covered
- . Coverage provided worldwide through the BlueCard® program
- . Qualified dependents and students are covered to age 26.

- . \$15 copay
- . \$15 copay
- . None
- . None
- . None
- . None

type of care/plan benefits	Coverage*
----------------------------	-----------

Preventive Health Care Services

- . Well child visits
- . Adult routine physical exams

- . Adult immunizations
- . Mammography
- . Pap smear
- . Routine GYN exam
- . Prostate cancer screening
- . Routine vision

- . Colonoscopy

Physician Office Services

- . Diagnostic office visits
- . Diagnostic x-rays
- . Diagnostic laboratory and pathology
- . Allergy tests
- . Allergy injections
- . Chemotherapy
- . Radiation therapy
- . Second medical opinion
- . Sick Child Visits

Maternity Services

- . Prenatal and postpartum care
- . Hospital care for mom (including delivery)

- . Newborn nursery care

Prescription Drug

- . Short-term and maintenance drugs

- . Covered in full
- . Covered in full, limited to one exam per year according to national guidelines
- . Covered in full
- . Covered in full
- . Covered in full
- . Covered in full
- . \$15 copay
- . \$15 copay for one routine exam per year; \$100 eyewear allowance available per year
- . Preventative covered in full

- . \$15 copay per visit, \$0 for children to age 19 for PCP
- . \$15 copay, precertification applies to MRI, PET and CAT scans
- . Covered in full
- . \$15 copay per visit
- . \$15 copay per visit
- . Covered in full
- . Covered in full
- . \$15 copay per visit
- . \$0 to age 19

- . \$5 copay for the first 10 visits then covered in full
- . Hospital-Covered in full; Delivery-Covered in full with \$50 copayment in combination with prenatal and postpartum care.
- . Covered in full

- . \$5/\$20/\$35 for retail and mail order. Retail 1 copay for 30 day supply or 3 copay for 90 day supply. Mail order 1 copay for 90 day supply

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 . Pulmonary Rehabilitation . Hemodialysis <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 and supplies . External prosthetics and orthotics . Chiropractic . Acupuncture . Dental . Hearing . Private Duty Nursing . Pre-admission Testing 	<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 . Covered in full . Covered in full <ul style="list-style-type: none"> . \$50 copay per visit, unless admitted within 24 hours . \$25 copay per visit . \$15 copay <ul style="list-style-type: none"> . \$15 copay per visit, precertification applies to MRI, PET and CAT scans . Covered in full . \$15 copay per visit . Covered in full . Covered in full . \$15 copay per visit . Covered in full <ul style="list-style-type: none"> . Covered in full, precertification applies . \$15 copay per visits, services can be provided in an outpatient facility or in a provider office . Covered in full, precertification applies . \$15 copay per visit <ul style="list-style-type: none"> . \$15 copay . Covered in full for up to 120 days per year, 360 day lifetime max, precertification applies . Covered in full for unlimited visits, precertification applies . Covered in full for unlimited days . \$15 copay 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% . \$15 copay per visit . Covered at 50%, up to 10 visits per year . Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly . \$15 copay for diagnostic exam, no coverage for routine exam, two hearing aids covered every 3 years for children to age 19 . Covered in full inpatient and at home . Covered in full

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. 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.