

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 . Precertification Requirement . 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 <p>. Lifetime maximum</p>	<ul style="list-style-type: none"> . \$5 copay . Not required . Covered based on scheduled allowance . Coverage provided worldwide through the BlueCard program. . Qualified dependents and students are covered to age 26. . Not covered . All Hospital Admissions - Penalty \$250 . January 1, 2016 - December 31, 2016 <ul style="list-style-type: none"> . \$5 Copay, out-of-network 20% coinsurance . \$5 copay, out of network 20% coinsurance . 20%, unless noted . None . \$6,350 Individual/\$12,700 Family, All medical & drug copays, coinsurances and deductibles are applied to the out of pocket maximum for in-network benefits only. . None

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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 Care . Hospital care for mom (including delivery) 	<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 at 100% in-network & out-of-network . Covered at 100% for 1 exam per year in-network & out-of-network . Covered at 100% in-network & out of network . Covered at 100% in-network & out of network . Not Covered . Covered at 100% in-network & out of network <ul style="list-style-type: none"> . \$5 copay in-network, 20% coinsurance out-of-network . Covered at 100% in-network & out-of-network . Covered at 100% in-network & out-of-network . \$5 copay in network, 20% coinsurance out-of-network . Covered at 100% in-network, 20% coinsurance out-of-network . Covered at 100% in-network & out-of-network . Covered at 100% in-network & out-of-network <ul style="list-style-type: none"> . Covered at 100% in-network & out-of-network . Covered at 100% in-network & out-of-network

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<ul style="list-style-type: none"> Newborn nursery care 	<ul style="list-style-type: none"> Covered at 100% in-network & out-of-network
<p>Prescription Drug</p> <ul style="list-style-type: none"> Short-term and maintenance drugs 	<ul style="list-style-type: none"> \$15/\$30/\$60 in-network only. No coverage for out-of-network
<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 at 100% in-network & out-of-network Covered at 100% in-network, 20% coinsurance out-of-network Covered at 100% in-network & out-of-network Covered at 100% in-network, 20% coinsurance out-of-network Covered at 100% in-network, 20% coinsurance out-of-network
<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 at 100% in-network & out-of-network Covered at 100% in-network & out-of-network Covered at 100% in-network & out-of-network
<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 at 100% in-network & out-of-network
<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 at 100% in-network & out-of-network Covered at 100% in-network, 20% coinsurance out-of-network Covered at 100% in-network & out-of-network Covered at 100% in-network & out-of-network
<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 Reproductive Procedures Autism Applied Behavior Analysis 	<ul style="list-style-type: none"> Covered at 100% in-network & out-of-network \$5 copay in-network, 20% coinsurance out-of-network Covered at 100% in-network & out-of-network Covered at 100% in-network & out-of-network \$5 copay in-network, 20% coinsurance out-of-network Not covered Not covered Not covered Covered at 100% in-network, 20% coinsurance out-of-network \$5 copay in-network, 20% coinsurance out-of-network,

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.