

Type of Care/Plan Benefits	Coverage
Plan features • Primary Care Physician (PCP) • Referrals • Out of network benefits • Out of area benefits • Student/Dependent coverage • Domestic partner Plan cost-sharing highlights • Office visit copay (Primary Care Physician) • Office visit copay (Specialist) • Coinsurance • Deductible • Annual coinsurance maximum • Annual pharmacy maximum	• 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 • 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 • \$50 individual / \$150 family, enhanced benefits only • \$400 individual / \$1200 family, enhanced benefits only • \$2000 individual / \$6000 family
type of care/plan benefits	Coverage
Wellness Incentive • Stay healthy with great programs and incentives! 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 Maternity Services • Prenatal and postpartum care • Hospital care for mom (including delivery) • Newborn nursery care Prescription Drug	• 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 • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Not covered • Covered in full • 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 • Covered in full • Covered in full • Covered in full

Type of Care/Plan Benefits	Coverage
• Short-term and maintenance drugs are covered up to a 30-day supply at participating retail pharmacies; 90-day supply (subject to two copays per 90-day supply) is available through Express Scripts mail order pharmacy. Contraceptives included. Inpatient Hospital Benefits • Hospital benefits • Physician visits in the hospital • Inpatient physical rehabilitation • Surgery • Anesthesia Emergency Care • Emergency room care • Freestanding urgent care center • Ambulance Outpatient Hospital Benefits • Diagnostic x-rays • Diagnostic laboratory and pathology • Surgical care • Chemotherapy • Radiation therapy Mental Health and Chemical Dependence • Inpatient mental health care • Outpatient mental health care • Inpatient chemical dependence • Outpatient chemical dependence Other Services • Diabetic insulin and supplies • Skilled nursing facility • Home care • Hospice • Outpatient therapy • Durable medical equipment • External prosthetics • Chiropractic • Acupuncture • Dental • Hearing	• \$15/\$30/\$45 with edits • Covered in full for unlimited days • Covered in full • Covered in full for 30 days. After basic benefits exhausted, not subject to deductible and coinsurance for unlimited days • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full for unlimited days • Covered in full for unlimited visits • Covered in full for unlimited days • Covered in full for unlimited visits • Covered in Full • Covered in full for 100 days. After basic benefits exhausted, not subject to deductible and coinsurance 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 for unlimited days • Subject to deductible and coinsurance, limited to 100 visits per calendar year • Subject to deductible and coinsurance • Subject to deductible and coinsurance • Subject to deductible and coinsurance • Not covered • Not covered • Not covered