



Type of Care/Plan Benefits	Coverage
<p><b>Plan features</b></p> <ul style="list-style-type: none"><li>• Primary Care Physician (PCP)</li><li>• Referrals</li><li>• Out of Network Benefits</li><li>• Out of Area Benefits</li><li>• Student/Dependent Coverage</li><li>• Domestic Partner</li></ul> <p><b>Plan cost-sharing highlights</b></p> <ul style="list-style-type: none"><li>• Office Visit Copay (Primary Care Physician)</li><li>• Office Visit Copay (Specialist)</li><li>• Coinsurance</li><li>• Deductible</li><li>• Coinsurance Out of Pocket Maximum</li></ul>	<ul style="list-style-type: none"><li>• No copay, office visit covered subject to deductible and coinsurance</li><li>• Not required</li><li>• Covered</li><li>• Coverage provided worldwide through BlueCross BlueShield Global Core</li><li>• Qualified dependents and students are covered to age 26</li><li>• Covered</li></ul> <ul style="list-style-type: none"><li>• No copay, office visit covered subject to deductible and coinsurance</li><li>• No copay, office visit covered subject to deductible and coinsurance</li><li>• 20%</li><li>• \$50 individual / \$150 family, enhanced benefits only</li><li>• \$400 Individual / \$1,200 Family</li></ul>

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<p><b>Wellness Incentive</b></p> <ul style="list-style-type: none"><li>• Stay healthy with great programs and incentives!</li></ul> <p><b>Preventive Services</b></p> <ul style="list-style-type: none"><li>• Well Child Visits and Immunizations</li><li>• Routine Physical Examinations</li><li>• Adult Immunizations</li><li>• Routine Mammogram</li><li>• Prostate Cancer Screening</li><li>• Routine GYN &amp; Cervical Screening</li><li>• Bone Density Testing</li><li>• Colonoscopy</li></ul> <p><b>Physician Office Services</b></p> <ul style="list-style-type: none"><li>• Diagnostic Office Visits &amp; Diagnostic GYN Visits</li><li>• Diagnostic Imaging, X-Rays, CAT, MRI</li><li>• Diagnostic Laboratory and Pathology</li><li>• Allergy Tests and Treatment</li><li>• Allergy Injections</li><li>• Chemotherapy</li><li>• Radiation Therapy</li><li>• Chiropractic Care</li></ul> <p><b>Maternity Services</b></p> <ul style="list-style-type: none"><li>• Prenatal Care</li><li>• Maternity Care</li><li>• Newborn Care</li></ul> <p><b>Prescription Drug</b></p>	<ul style="list-style-type: none"><li>• Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids.</li></ul> <ul style="list-style-type: none"><li>• Covered in full</li><li>• Covered in full, 1 exam per calendar year</li><li>• Covered in full</li><li>• Covered in full</li><li>• Covered in full</li><li>• Covered in full</li><li>• Covered in full</li><li>• Covered in full</li></ul> <ul style="list-style-type: none"><li>• Subject to deductible and coinsurance</li><li>• Covered in full</li><li>• Covered in full</li><li>• Subject to deductible and coinsurance</li><li>• Subject to the deductible and coinsurance</li><li>• Covered in full</li><li>• Covered in full</li><li>• Subject to the deductible and coinsurance</li></ul> <ul style="list-style-type: none"><li>• Covered in full</li><li>• Covered in full</li><li>• Covered in full</li></ul> <ul style="list-style-type: none"><li>• \$1 OOP Max \$1,000/\$3,000 \$0 Cost Share for Insulin</li></ul>

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<b>Hospital Inpatient Services</b> <ul style="list-style-type: none"> <li>• Hospital Benefits</li> <li>• Physician Visits in the Hospital</li> <li>• Inpatient Physical Rehabilitation</li> <li>• Surgery</li> <li>• Anesthesia</li> </ul> <b>Emergency Services</b> <ul style="list-style-type: none"> <li>• Facility Emergency Room</li> <li>• Freestanding Urgent Care Center</li> <li>• Prehospital Emergency Services/Transportation</li> </ul> <b>Hospital Outpatient Services</b> <ul style="list-style-type: none"> <li>• Pre-admission/Pre-operative Testing</li> <li>• Diagnostic Imaging, X-Ray, CAT, MRI</li> <li>• Diagnostic Laboratory and Pathology</li> <li>• Surgical Care including Surgicenters &amp; Freestanding Facilities</li> <li>• Chemotherapy</li> <li>• Radiation therapy</li> <li>• Dialysis</li> </ul> <b>Mental Health Care and Substance Use</b> <ul style="list-style-type: none"> <li>• Inpatient Mental Health Care</li> <li>• Outpatient Mental Health Care</li> <li>• Inpatient Substance Use, Detox, Rehab &amp; Residential Care</li> <li>• Outpatient Substance Use Treatment</li> </ul> <b>Other Services</b> <ul style="list-style-type: none"> <li>• Treatment of Diabetes &amp; Supplies</li> <li>• Skilled Nursing Facility</li> <li>• Home Care</li> <li>• Hospice</li> <li>• Covered Therapies (Physical, Speech and Occupational)</li> <li>• Cardiac Rehabilitation &amp; Pulmonary Rehabilitation Therapy</li> <li>• Durable Medical Equipment (DME)</li> <li>• External Prosthetics/Orthotics</li> <li>• Medical Supplies</li> <li>• Diagnostic Hearing Exam</li> <li>• Diagnostic Eye Exam</li> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full, unlimited days</li> <li>• Covered in full</li> <li>• Covered in full, 30 days. (After basic benefit is exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible)</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full, unlimited days</li> <li>• Covered in full</li> <li>• Covered in full, unlimited days</li> <li>• Covered in full</li> <li>• Subject to deductible and coinsurance</li> <li>• Covered in full</li> <li>• Covered in full, 60 visits per calendar year. (After basic benefit is exhausted, additional coverage subject to \$50 deductible and 20% coinsurance up to 325 visits)</li> <li>• Covered in full, (includes 5 bereavement counseling visits)</li> <li>• Subject to deductible and coinsurance, unlimited</li> <li>• Covered in full,</li> <li>• Subject to deductible and coinsurance</li> <li>• Subject to deductible and coinsurance</li> <li>• Subject to deductible and coinsurance</li> <li>• Subject to deductible and coinsurance, routine not covered</li> <li>• Subject to deductible and coinsurance, routine not covered</li> <li>• Not covered</li> </ul>

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. Please contact Dedicated Customer Service with any questions at (877) 253-4797. Pre-certification required for organ transplants and non-mandated reproductive procedures (GIFT & ZIFT).