

**Healthy Blue \$15 Copay**

**Healthy Blue \$30 Copay**

**BluePoint2 \$15**

**General Information**

**Cost Sharing Expenses**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Deductible - Single	\$0	\$500		\$0	\$500		\$0	\$300	
Deductible - Family	\$0	\$1,500		\$0	\$1,500		\$0	\$750	
Coinsurance	0%	20%		0%	20%		0%	25%	
Annual Out of Pocket Maximum - Single	\$4,200	\$4,620		\$4,200	\$4,620		\$6,350	\$6,350	
Annual Out of Pocket Maximum - Family	\$12,600	\$13,860		\$12,600	\$13,860		\$12,700	\$12,700	

**Office Visit Cost Shares**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cost Share - Primary Care	\$15 Copayment	20% Coinsurance Subject to Deductible		\$30 Copayment	20% Coinsurance Subject to Deductible		\$15 Copayment	25% Coinsurance Subject to Deductible	
Cost Share - Specialist	\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible		\$15 Copayment	25% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	\$0 Copayment	20% Coinsurance Subject to Deductible		\$0 Copayment	20% Coinsurance Subject to Deductible		\$5 Copayment	25% Coinsurance Subject to Deductible	

**Plan Limits**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Yes			Yes			No

**Who is Covered**

## Healthy Blue \$15 Copay

## Healthy Blue \$30 Copay

## BluePoint2 \$15

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Domestic Partner Coverage			Not Covered			Not Covered			Not Covered

### Inpatient Services

#### Inpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Services	\$150 Copayment	20% Coinsurance Subject to Deductible		\$500 Copayment	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Mental Health Care	\$150 Copayment	20% Coinsurance Subject to Deductible		\$500 Copayment	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Substance Use Detoxification	\$150 Copayment	20% Coinsurance Subject to Deductible		\$500 Copayment	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Skilled Nursing Facility	\$150 Copayment	20% Coinsurance Subject to Deductible	45 Days per year	\$500 Copayment	20% Coinsurance Subject to Deductible	45 Days per year	Covered in Full	25% Coinsurance Subject to Deductible	120 Days Per Year
Physical Rehabilitation	\$150 Copayment	20% Coinsurance Subject to Deductible	60 Days per year	\$500 Copayment	20% Coinsurance Subject to Deductible	60 Days per year	Covered in Full	25% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	

#### Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	

### Outpatient Facility Services

#### Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	\$75 Copayment	20% Coinsurance Subject to Deductible		\$250 Copayment	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	

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Benefit Name	Healthy Blue \$15 Copay			Healthy Blue \$30 Copay			BluePoint2 \$15		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Diagnostic X-ray	\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible		\$15 Copayment	25% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Radiation Therapy	\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Chemotherapy	\$15 Copayment	20% Coinsurance Subject to Deductible		\$30 Copayment	20% Coinsurance Subject to Deductible		\$15 Copayment	25% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service		Inclusive of Primary Service	Inclusive of Primary Service		Inclusive to Primary Service	Inclusive to Primary Service	
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Mental Health Care	\$15 Copayment \$0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible		\$30 Copayment \$0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible		\$15 Copayment	25% Coinsurance Subject to Deductible	
Substance Use Care	\$15 Copayment \$0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible		\$30 Copayment \$0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible		\$15 Copayment	25% Coinsurance Subject to Deductible	

## Home and Hospice Care

### Home Care

Benefit Name	Healthy Blue \$15 Copay			Healthy Blue \$30 Copay			BluePoint2 \$15		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	Covered in Full	20% Coinsurance Subject to \$50 Deductible	40 Visits per year	Covered in Full	20% Coinsurance Subject to \$50 Deductible	40 Visits per year	Covered in Full	25% Coinsurance Subject to \$50 Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to \$50 Deductible		Covered in Full	20% Coinsurance Subject to \$50 Deductible		Covered in Full	25% Coinsurance Subject to \$50 Deductible	

### Hospice Care

Benefit Name	Healthy Blue \$15 Copay			Healthy Blue \$30 Copay			BluePoint2 \$15		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	

## Outpatient and Office Professional Services

### Professional Services

## Healthy Blue \$15 Copay

## Healthy Blue \$30 Copay

## BluePoint2 \$15

Benefit Name	Healthy Blue \$15 Copay			Healthy Blue \$30 Copay			BluePoint2 \$15		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	Specialist - \$25 Copayment PCP - \$15 Copayment \$0 PCP Copay for	20% Coinsurance Subject to Deductible		Specialist - \$50 Copayment PCP - \$30 Copayment \$0 PCP Copay for	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - \$15 Copayment \$0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment \$0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Telehealth	Specialist - \$25 Copayment PCP - \$15 Copayment \$0 PCP Copay for	20% Coinsurance Subject to Deductible		Specialist - \$50 Copayment PCP - \$30 Copayment \$0 PCP Copay for	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - Covered in Full \$0 PCP Copay for members to age 19.	Not Covered		PCP / Specialist - Covered in Full \$0 PCP Copay for members to age 19.	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Chiropractic Care	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Allergy Testing	Specialist - \$25 Copayment PCP - \$15 Copayment \$0 PCP Copay for	20% Coinsurance Subject to Deductible		Specialist - \$50 Copayment PCP - \$30 Copayment \$0 PCP Copay for	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	Specialist - \$25 Copayment PCP - \$15 Copayment \$0 PCP Copay for	20% Coinsurance Subject to Deductible		Specialist - \$50 Copayment PCP - \$30 Copayment \$0 PCP Copay for	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per Year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per Year	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	1 Exam per year

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### Rehab and Habilitation

#### Outpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year
Occupational Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year
Speech Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year

#### Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year
Occupational Rehabilitation	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year
Speech Rehabilitation	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year

### Preventive Services

#### Preventive Professional Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per calendar year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per calendar year
Adult Immunizations	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	2 Exam per year
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	

### Preventive Facility Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	2 per year
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prostate Cancer Screening	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Facility

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Facility	\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible		\$15 Copayment	25% Coinsurance Subject to Deductible	

## Other Benefits

### Additional Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Treatment of Diabetes Insulin and Supplies	PCP / Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	25% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - Not Covered	Not Covered	
Acupuncture	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per calendar year
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

### Diagnoses

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Reimbursement for Travel and Lodging Expenses	PCP / Specialist - Covered	Covered	\$4,000 Reimbursement Per Plan Year	PCP / Specialist - Covered	Covered	\$4,000 Reimbursement Per Plan Year	PCP / Specialist - Covered	Covered	\$4,000 Reimbursement Per Plan Year

## Emergency Services

### ER Facility

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Facility Emergency Room Visit	\$75 Copayment	\$75 Copayment		\$250 Copayment	\$250 Copayment		\$50 Copayment	\$50 Copayment	

### Transportation

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prehospital Emergency and Transportation - Ground or Water	\$75 Copayment	\$75 Copayment		\$250 Copayment	\$250 Copayment		\$25 Copayment	\$25 Copayment	

### Urgent Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Urgent Care Center Facility Visit	\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible		\$25 Copayment	25% Coinsurance Subject to Deductible	

### Ancillary Benefits

#### Vision

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Pediatric Eye Exams - Routine	\$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year	\$50 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year	\$15 Copayment	Not Covered	1 Exam per calendar year
Pediatric Eyewear - Routine	20% Coinsurance	20% Coinsurance Subject to Deductible	1 Pair Per year	20% Coinsurance	20% Coinsurance Subject to Deductible	1 Pair Per year	20% Coinsurance	Not Covered	1 Pair per calendar year
Adult Eye Exams - Routine	\$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year	\$50 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year	\$15 Copayment	Not Covered	1 Exam every 2 calendar years
Adult Eyewear - Routine	Covered	Covered	\$60 Reimbursement per year	Covered	Covered	\$60 Reimbursement per year	Covered	Not Covered	\$60 Reimbursement every 2 calendar years

### Rx Benefits

#### Rx Plan

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Rx Plan			\$5/\$25/\$50, \$0 Gen for Kids			\$5/\$35/\$70, \$0 GEN FOR KIDS			\$5/\$15/\$30

#### Rx Benefits



### Healthy Blue \$15 Copay

### Healthy Blue \$30 Copay

### BluePoint2 \$15

Benefit Name	Healthy Blue \$15 Copay			Healthy Blue \$30 Copay			BluePoint2 \$15		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Days Supply Per Retail Order	30			30			90		
Days Supply Per Mail Order	90			90			90		
Copays Per Mail Order Supply	2			2			2		

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This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits. \* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.