New Prague Benefit Comparison

Effective 7/1/2014

	TRIPLE GOLD			$500 CMM		VEBA	
	Single - $723.14			Single - $637.42		Single - $589.06	
	Family - $1,753.45			Family - $1,546.84		Family - $1,429.25	
BENEFIT	**TRIPLE GOLD**			**$500 CMM**		**VEBA**	
	IN-NETWORK (PCC)	**EXTENDED NETWORK**	**OUT-OF-NETWORK***	**IN-NETWORK**	**OUT-OF-NETWORK***	**IN-NETWORK**	**OUT-OF-NETWORK***
Lifetime Maximum	Unlimited			Unlimited		Unlimited	
Deductible		(Combine Extended and Out of Network*)		(Deductible Waived for Accidents)		(Combine Across Networks*)	
¨ Single	N/A	$200		$500		$1,200	
¨ Family	N/A	$600		$1,000		$2,400	
Medical Out of Pocket Maximum		(Combine Extended and Out of Network*)		(Combine Across Network*)		Same as Deductible in Network	
¨ Single	$500	$2,500		$1,200		Out of Network* $3,500	
¨ Family	$1,000	$5,000		$2,400		Out of Network* $6,500	
Drug Out of Pocket Maximum							
¨ Single	N/A	N/A	N/A	$300		Combined with Medical	
¨ Family	N/A	N/A	N/A	$500		Combined with Medical	
Physician Office Visits	100% after $15 copay	80% after deductible	75% after deductible*	80% after deductible	80% after deductible*	100% after deductible	80% after deductible*
Physician Services other than Office Call	100%	80% after deductible	75% after deductible*	80% after deductible	80% after deductible*	100% after deductible	80% after deductible*
Diagnostic Lab & X-ray in office	100%	80% after deductible	75% after deductible*	80% after deductible	80% after deductible*	100% after deductible	80% after deductible*
Preventive Care							
¨ Routine physicals	100%	80% after deductible	75% after deductible*	100%	80% after deductible*	100%	80% after deductible*
¨ Lab tests							
¨ Vision care							
¨ X-rays							
¨ Cancer Screenings	100%	80% after deductible	75% after deductible*	100%	100%*	100%	80% after deductible*
¨ Prenatal							
¨ Well Child	100%	100%	100%	100%	100%*	100%	100%
Inpatient Physician Services	100%	80% after deductible	75% after deductible*	80% after deductible	80% after deductible *	100% after deductible	80% after deductible *

BENEFIT	TRIPLE GOLD			$500 CMM		VEBA	
	IN-NETWORK (PCC)	EXTENDED NETWORK	OUT-OF-NETWORK*	IN-NETWORK	OUT-OF-NETWORK*	IN-NETWORK	OUT-OF-NETWORK*
Inpatient Hospital Services Includes Mental/Chemical Health	100%	80% after deductible	75% after deductible*	80% after deductible	80% after deductible*	100% after deductible	80% after deductible*
Outpatient Behavioral Health Care Includes Provider and Facility Services	100% after $15 copay	80% after deductible	75% after deductible*	80% after deductible	80% after deductible*	100% after deductible	80% after deductible*
Outpatient Services Includes Provider and Facility Services	100%	80% after deductible	75% after deductible*	80% after deductible	80% after deductible*	100% after deductible	80% after deductible*
Emergency Room							
¨Accidental Injuries	100% after $40 copay	100% after $40 copay	100% after $40 copay*	80%	80%*	100% after deductible	80% after deductible* for Professional. 100% coverage after deductible for Facility
¨ Medical Emergencies	(Copay waived if admitted)	(Copay waived if admitted)	(Copay waived if admitted)	80% after deductible	80% after deductible*	100% after deductible	
Chiropractic Care							
(Manipulations and therapies)	100% after $15 copay	80%	75%*	80% after deductible	80% after deductible*	100% after deductible	80% after deductible in Extended Network; No coverage Out of Network*
	80% Other services		($500 Max Benefit per calendar year)		($500 Max Benefit per calendar year)		
Dental							
¨ Accidental-treatment	100% after $15 Copay for Office Visit;	80%	75% after deductible*	80% after deductible	80% after deductible*	100% after deductible	80% after deductible*
¨ Cleft Lip & Palate under age 18							
¨ TMJ	80% Non-Office Visit						
¨ Oral Surgery						**No coverage for Oral Surgery & Root Canal Therapy**	**No coverage for Oral Surgery & Root Canal Therapy**
¨ Root Canal Therapy							

<table>
<tr><th rowspan="2">BENEFIT</th><th colspan="3">TRIPLE GOLD</th><th colspan="2">$500 CMM</th><th colspan="2">VEBA</th></tr>
<tr><th>IN-NETWORK (PCC)</th><th>EXTENDED NETWORK</th><th>OUT-OF-NETWORK*</th><th>IN-NETWORK</th><th>OUT-OF-NETWORK*</th><th>IN-NETWORK</th><th>OUT-OF-NETWORK*</th></tr>
<tr><td rowspan="3">Rehabilitation Services</td><td rowspan="2">100% after $15 Copay for Office Visit;</td><td rowspan="3">80%</td><td>75% after deductible*</td><td rowspan="3">80% after deductible</td><td>80% after deductible*</td><td rowspan="3">100% after deductible</td><td rowspan="3">80% after deductible in Extended Network; No coverage Out of Network*</td></tr>
<tr><td>Includes Physical, Occupational, and Speech Therapy</td><td rowspan="2">80% Non-Office Visit</td><td>PT/OT/ST</td><td>PT/OT/ST</td></tr>
<tr><td>$500 combined max per year</td><td>$500 combined max per year</td></tr>
<tr><td>Ambulance</td><td>80%</td><td>80%</td><td>80%*</td><td>80% after deductible</td><td>80% after deductible*</td><td>100% after deductible</td><td>100% after deductible*</td></tr>
<tr><td>Medical Supplies</td><td>80%</td><td>80%</td><td>75%*</td><td>80% after deductible</td><td>80% after deductible*</td><td>100% after deductible</td><td>80% after deductible*</td></tr>
<tr><td>Prescription Drugs</td><td colspan="7"></td></tr>
<tr><td rowspan="3">34 day supply or 100 units whichever is greater</td><td colspan="3">$8 Preferred brand</td><td colspan="2">$8 Generic</td><td>100% after deductible</td><td>100% after deductible</td></tr>
<tr><td colspan="3" rowspan="2">$12 Non-preferred brand</td><td colspan="2">$16 Preferred brand</td><td>31 day supply Retail</td><td>31 day supply Retail</td></tr>
<tr><td colspan="2">$32 Non-preferred brand</td><td>90 day Rx</td><td>90 day Rx</td></tr>
</table>

* Always use a Blue Cross Blue Shield provider. For some services, there is no coverage at nonparticipating providers. Nonparticipating providers may not accept our allowed amount as payment in full and you may be responsible for the balance. You may also be required to file your own claims at nonparticipating providers. To locate a provider anywhere in the USA, use our web site www.bluecrossmn.com or call 1-800-810-BLUE.

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This summary is intended as a guide to the coverage provided. For a complete description of the benefits, please refer to your certificate.