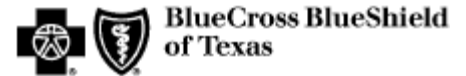


PPO Insured Standard with Network Deductible and Split Copay



BENEFIT HIGHLIGHTS *Prepared for*
Gebo Distributing Company
Effective Date: 1/1/17 BA#

BlueChoice Network

This is a general summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions. **Partial matrix page attached**

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
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Deductibles

Per-admission Deductible Calendar Year Deductible <i>Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses</i> Three-month Deductible carryover applies Deductible credit from prior carrier (applied on initial group enrollment only)	NONE \$2,500 Individual / \$5,000 Family No Yes No	NONE \$5,000 Individual / \$10,000 Family No Yes No
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Out-of-Pocket Maximum

Deductible applies to Out-of-Pocket Copayment applies to Out-of-Pocket ** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%. Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	\$6,000 Individual / \$12,000 Family Yes – no option Yes – no option Network Deductible & Out-of-Pocket will only apply toward Network Deductible & Out-of-Pocket Maximum Yes No	\$15,000 Individual / \$30,000 Family Yes** Yes** Out-of-Network Deductible & Out-of-Network Out-of-Pocket will only apply toward Out-of-Network Deductible & Out-of-Network Out-of-Pocket Maximum No
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Copayment Amounts Required

Physician office visit/consultation: Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider <i>Refer to Medical/Surgical Expenses section for more information</i> Urgent Care center visit <i>Refer to Urgent Care section for more information</i>	\$35 Primary Care Copayment \$55 Specialty Care Copayment \$50 Copayment Amount	Unlimited
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Maximum Lifetime Benefits Per Participant

Inpatient Hospital Expenses

Inpatient Hospital Expenses

All services must be preauthorized All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Penalty for failure to preauthorize services	70% of Allowable Amount after Deductible None	50% of Allowable Amount after Deductible \$250
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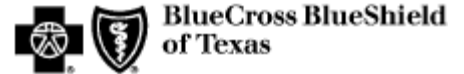
Medical/Surgical Expenses

Medical / Surgical Expenses

Services performed during the office visit/consultation when rendered by a Primary Care Provider, including lab and x-ray (does not include Certain Diagnostic Procedures and surgical services) Services performed during the office visit/consultation when services rendered by a Specialty Care Provider, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services) -Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures) -Physician surgical services performed in any setting	100% of Allowable Amount after \$35 Primary Care Copayment** 100% of Allowable Amount after \$55 Specialty Care Copayment 100% of Allowable Amount 70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible 50% of Allowable Amount after Deductible 50% of Allowable Amount after Deductible 50% of Allowable Amount after Deductible
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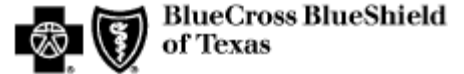
** Primary Care/Specialty Care copayments are defined in the Overall Payment Provisions section in this document.

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Medical / Surgical Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> -Physician inpatient hospital visits -Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan -Home Infusion Therapy (<i>Services must be preauthorized</i>) -All other outpatient services and supplies 	<p>70% of Allowable Amount after Deductible</p> <p>70% of Allowable Amount after Deductible</p> <p>70% of Allowable Amount after Deductible</p> <p>70% of Allowable Amount after Deductible</p>	<p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p>
<p>Virtual Visit MDLIVE (standard offering) Note: Must mirror PCP office visit benefit Medical & Behavioral Health Medical</p> <p>Note: Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder Behavioral Health</p> <p>Note: Behavioral Health Virtual Visit applies to MHP</p>	<p>100% of Allowable Amount after \$35 Copayment Amount</p> <p>100% of Allowable Amount after \$35 Copayment Amount</p>	<p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p>
<p>In Vitro Fertilization Services</p>	<p>Decline</p>	
Extended Care Expenses		
<p>Extended Care Expenses All services must be preauthorized Skilled Nursing Facility Home Health Care Hospice Care</p>	<p>100% of Allowable Amount</p>	<p>50% of Allowable Amount after Deductible</p> <p>Limited to 30 day maximum each Year* Limited to 60 visit maximum each Year* Unlimited</p>
Special Provisions Expenses		
<p>Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)</p>		
<p>Inpatient Services Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)</p> <ul style="list-style-type: none"> -Hospital services (facility) -Physician services <p>Penalty for failure to preauthorize services Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services</p> <p>Outpatient Services -Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing)</p> <ul style="list-style-type: none"> -All outpatient services and psychological testing 	<p>70% of Allowable Amount after Deductible</p> <p>70% of Allowable Amount after Deductible</p> <p>None</p> <p>100% of Allowable Amount after \$35 Primary Care Copayment Amount</p> <p>70% of Allowable Amount after Deductible</p>	<p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p> <p>\$250</p> <p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p>
Emergency Room/Treatment Room		
<p>Accidental Injury & Emergency Care -Facility charges</p> <ul style="list-style-type: none"> -Physician charges <p>Non-Emergency Care -Facility charges</p>	<p>70% of Allowable Amount after deductible</p> <p>70% of Allowable Amount after Deductible</p> <p>70% of Allowable Amount after Deductible</p>	<p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p>

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-Physician charges	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (does not include Certain Diagnostic Procedures and surgical services)	100% of Allowable Amount after \$50 Copayment Amount	50% of Allowable Amount after Deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible

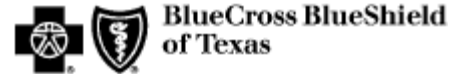
* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
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Ground and Air Ambulance Services	70% of Allowable Amount after Deductible	
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	100% of Allowable Amount	50% of Allowable Amount after Deductible
Immunizations for Dependent children through the date of the child's 6 th birthday	100% of Allowable Amount	100% of Allowable Amount
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function	Covered same as any other sickness	Covered same as any other sickness
Hearing Aids	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Hearing Aid Maximum	Hearing aids are subject to 1 per ear per 36 month period	
Organ and Tissue Transplant Services	Covered same as any other sickness Refer to benefit booklet for details	Covered same as any other sickness Refer to benefit booklet for details
Physical Medicine Services		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Maximum	Limited to 35 visits each Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

PPO Insured Standard with Network Deductible and Split Copay



Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List**	<input checked="" type="checkbox"/> Enhanced (Previously drug list 2) <input type="checkbox"/> Performance (all standard UM must apply) <i>Note: For non-grandfathered insured business, enhanced is standard. Non-grandfathered insured business may optionally select Performance.</i>	
Compound Drugs	Not Covered	
Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant	Exclude Prescription Strength NSA's	
Proton Pump Inhibitors	Generics coverage only	
Prescribed over-the-counter (OTC) medications	Not covered <i>Exclude prescription orders for which there is an OTC product available with the same active ingredient(s) in the same strength (standard exclusion). Cover Omeprazole 20 mg Yes</i>	
Prescription Drug Deductible***	<input checked="" type="checkbox"/> None <input type="checkbox"/> All benefits, including prescription drug benefits (retail and mail service) apply to Deductible shown on page 1. Deductible will apply to the Out-of-Pocket Maximum. <input type="checkbox"/> Separate Prescription Drug Deductible applies to Retail & Mail Service Pharmacy: Individual: \$ / Family: \$. Deductible will apply to the Out-of-Pocket Maximum.	
Prescription Drug Out-of-Pocket Maximum	<input type="checkbox"/> All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1. <input type="checkbox"/> Separate Prescription Drug Out-of-Pocket Maximum applies to Retail & Mail Service Pharmacy: Individual: \$ / Family: \$	
Vaccinations obtained through Pharmacies****	Yes, all ACA vaccines, including flu covered at pharmacies participating in Prime's Vaccination Network only: Zero Copayment Deductible does not apply (No OON Benefits)	
Retail Pharmacy (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name	\$15 Copayment Amount \$40 Copayment Amount \$70 Copayment Amount	50% of Allowable Amount minus Copayment Amount 50% of Allowable Amount minus Copayment Amount 50% of Allowable Amount minus Copayment Amount
Specialty Drugs†	Mandatory Specialty applies: Available at in-network benefit level through Prime Specialty Pharmacy only. All other pharmacies will be payable at the non-participating pharmacy benefit level.	
Mail Order Program (Copayment amounts are based on a 90-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	Yes \$45 Copayment Amount \$120 Copayment Amount \$210 Copayment Amount	

PPO Insured Standard with Network Deductible and Split Copay



Rx Enhanced-Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when "Brand Medically Necessary" is not indicated and a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the Preferred or Non-Preferred Brand Name Copayment Amount.

* To locate a preferred/participating pharmacy in your area, go to myprime.com or contact customer service at the phone number on the back of your identification card.

**The standard and generics plus drug list is available at: bcbstx.com/member/rx_drugs.html

*** Three-month Deductible carryover does not apply to prescription drug deductible.

****Select Participating Pharmacies have been contracted to provide vaccination services. Each pharmacy may have age, scheduling, or other requirements that will apply. Members are encouraged to contact the store in advance. **Benefit does not include childhood immunizations, subject to state regulations.**

†For more information on the specialty drug program, call Prime Specialty Pharmacy at (877)627-6337.

Diabetes Supplies are available under the Prescription Drug benefits of your plan. Diabetic Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.

Standard UM Programs (prior authorization and step therapy) and exclusions apply, including auto updates and FastPath.

Note: To confirm standard benefits, refer to the Pharmacy page on Product Central on FYIBlue.