BlueOptions	Predictable Cost Plan
	Plan 10
COST SHARING (amount member pays)	
Office Services	
Physician Office Services	
In-Network Family Physician / In-Network Specialist	$20 Copay / DED[1] + 20% Coins[2]
Out-of-Network Office Visit / e-Office Visit	DED + 40% Coins
In-Network e-Office Visit (Family Physician / Specialist)	$10 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network Family Physician / In-Network Specialist	$20 Copay / DED + 20% Coins
Maternity (Rider available with certain plans)	Available
Allergy Injections (per visit) In-Network Family Physician	$10 Copay
Medical Pharmacy Included in Office Services Benefit. No separate member cost share for this benefit on this plan.	Not Applicable
Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network / Out-of-Network	$0 / 40% Coins
Mammograms	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.	
In-Network	
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	$200 Brand
Generic/Brand/Non-preferred	$15 / 40% / 40%
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered
Out-of-Network	
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	$200 Brand
Generic/Brand/Non-preferred	$15 / 50% / 50%
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered
Emergency Medical Care	
Urgent Care Centers In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED + 20% Coins / DED + 20% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED + 20% Coins
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS)	$100 Copay
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$100 Copay
Out-of-Network	DED + 40% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)	
In-Network (Option 1 / Option 2) / Out-of-Network	$200 Copay/$300 Copay/DED + 40% Coins
Mental Health / Substance Abuse	
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum
Other Provider Services	
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC In-Network & Out-of-Network	In-Network DED + 20% Coins
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY
Home Health Care (subject to DED + Coins)	20 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	$100 Copay / DED + 40% Coins
Provider Services Rendered at an ASC (Surgeon)	
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days
In-Network (Option 1 / Option 2)	$750 Copay / $1,000 Copay
Out-of-Network	PAD + DED + 40% Coins
Outpatient Hospital Facility Services (per visit)	
In-Network (Option 1 / Option 2) / Out-of-Network	$200 Copay/$300 Copay/DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED + 20% Coins / DED + 20% Coins
Financial Features	
Deductible (DED) (per person/family aggregate)	
In-Network	$500 / Not Applicable
Out-of-Network	Combined w/In-Network
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 40%
Out-of-Pocket Maximum (per person/family aggregate)	
In-Network	$4,000 / $8,000
Out-of-Network	$25,000 / $25,000
Total Lifetime Maximum Benefit	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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BlueOptions	Predictable Cost Plans	
COST SHARING (amount member pays)	**Plan 504**	**Plan 505**
Office Services		
Physician Office Services		
In-Network Family Physician / In-Network Specialist	$35 Copay / $50 Copay	$35 Copay / $50 Copay
Out-of-Network Office Visit / e-Office Visit	DED[1] + 40% Coins[2]	DED + 40% Coins
In-Network e-Office Visit (Family Physician / Specialist)	$10 Copay	$10 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	$250 Copay	$250 Copay
Maternity (Rider available with certain plans)	Available	Available
Allergy Injections (per visit) In-Network Family Physician	$10 Copay	$10 Copay
Medical Pharmacy In-Network Provider / Out-of-Network Provider	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max	$200 In-Network Monthly Member OOP Max
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	$0 / 40% Coins	$0 / 40% Coins
Mammograms	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.		
In-Network		
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	$300 Brand	$300 Brand
Generic/Brand/Non-preferred	$10 / 40% / 50%	$10 / 40% / 50%
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / $125 / $200	$25 / $125 / $200
Out-of-Network		
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	$300 Brand	$300 Brand
Generic/Brand/Non-preferred	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins	50% Coins
Emergency Medical Care		
Urgent Care Centers In-Network / Out-of-Network	$60 Copay / DED + 40% Coins	$60 Copay / DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED / DED	DED / DED
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED	In-Network DED
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)		
In-Network Diagnostic Services (except AIS)	$75 Copay	$75 Copay
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$250 Copay	$250 Copay
Out-of-Network	DED + 40% Coins	DED + 40% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / DED + 40% Coins	$0 / DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)		
In-Network (Option 1 / Option 2) / Out-of-Network	DED / DED + 40% Coins	DED / DED + 40% Coins
Mental Health / Substance Abuse		
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum
Other Provider Services		
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED	In-Network DED
Radiology, Pathology and Anesthesiology Provider Services at an ASC		
In-Network / Out-of-Network	In-Network DED	In-Network DED
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED / DED + 40% Coins	DED / DED + 40% Coins
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	10 Visits PCY	10 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY	60 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	DED / DED + 40% Coins	DED / DED + 40% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED / DED + 40% Coins	DED / DED + 40% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days	
In-Network (Option 1 / Option 2)	DED	DED
Out-of-Network	PAD + DED + 40% Coins	PAD + DED + 40% Coins
Outpatient Hospital Facility Services (per visit)		
In-Network - Therapy Services (Option 1 / Option 2)	$55 Copay / $70 Copay	$55 Copay / $70 Copay
In-Network - All Other Services (Option 1 / Option 2)	DED	DED
Out-of-Network	DED + 40% Coins	DED + 40% Coins
ER Facility Services (per visit) In-Network / Out-of-Network	DED / DED	DED / DED
Financial Features		
Deductible (DED) (per person/family aggregate)		
In-Network	$2,500 / $7,500	$3,500 / $10,500
Out-of-Network	$4,500 / $9,000	$5,500 / $11,000
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	0% / 40%	0% / 40%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$2,500 / $7,500	$3,500 / $10,500
Out-of-Network	$7,500 / $15,000	$8,500 / $17,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

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COST SHARING (amount member pays)	Predictable Cost Plans Plan 510	Plan 511
Office Services		
Physician Office Services		
In-Network Family Physician / In-Network Specialist	$35 Copay / DED + 20% Coins	$35 Copay / DED + 20% Coins
Out-of-Network Office Visit / e-Office Visit	DED[1] + 40% Coins[2]	DED + 40% Coins
In-Network e-Office Visit (Family Physician / Specialist)	$10 Copay	$10 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	$250 Copay	$250 Copay
Maternity (Rider available with certain plans)	Available	Available
Allergy Injections (per visit) In-Network Family Physician	$10 Copay	$10 Copay
Medical Pharmacy In-Network Provider / Out-of-Network Provider	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max	$200 In-Network Monthly Member OOP Max
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	$0 / 40% Coins	$0 / 40% Coins
Mammograms	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.		
In-Network		
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	$1,500 Brand	$1,500 Brand
Generic/Brand/Non-preferred	$10 / 40% / 50%	$10 / 40% / 50%
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / $125 / $200	$25 / $125 / $200
Out-of-Network		
Pharmacy Deductible ***Rx Deductible is combined INN & OON & applies to Mail Order***	$1,500 Brand	$1,500 Brand
Generic/Brand/Non-preferred	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins	50% Coins
Emergency Medical Care		
Urgent Care Centers In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED + 20% Coins / DED + 20% Coins	DED + 20% Coins / DED + 20% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)		
In-Network Diagnostic Services (except AIS)	$75 Copay	$75 Copay
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$250 Copay	$250 Copay
Out-of-Network	DED + 40% Coins	DED + 40% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / DED + 40% Coins	$0 / DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)		
In-Network (Option 1 / Option 2) / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Mental Health / Substance Abuse		
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum
Other Provider Services		
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC		
In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	20 Visits PCY	20 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY	60 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	$200 Copay / DED + 40% Coins	$200 Copay / DED + 40% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days	
In-Network (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
Out-of-Network	PAD + DED + 40% Coins	PAD + DED + 40% Coins
Outpatient Hospital Facility Services (per visit)		
In-Network - Therapy Services (Option 1 / Option 2)	$55 Copay / $70 Copay	$55 Copay / $70 Copay
In-Network - All Other Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
ER Facility Services (per visit) In-Network / Out-of-Network	DED + 20% Coins / DED + 20% Coins	DED + 20% Coins / DED + 20% Coins
Financial Features		
Deductible (DED) (per person/family aggregate)		
In-Network	$500 / Not Applicable	$1,500 / Not Applicable
Out-of-Network	$1,500 / $4,500	$3,500 / $6,500
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 40%	20% / 40%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$4,000 / $8,000	$5,000 / $10,000
Out-of-Network	$25,000 / $25,000	$25,000 / $25,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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BlueOptions	Predictable Cost Plans		
COST SHARING (amount member pays)	**Plan 514**	**Plan 515**	**Plan 528**
Office Services			
Physician Office Services			
In-Network Family Physician / In-Network Specialist	$35 Copay / $75 Copay	$35 Copay / $75 Copay	$35 Copay / $50 Copay
Out-of-Network Office Visit / e-Office Visit	DED[1] + 50% Coins[2]	DED + 50% Coins	DED + 50% Coins
In-Network e-Office Visit (Family Physician / Specialist)	$10 Copay	$10 Copay	$10 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	$300 Copay	$300 Copay	$250 Copay
Maternity (Rider available with certain plans)	Available	Available	Not Available
Allergy Injections (per visit) In-Network Family Physician	$10 Copay	$10 Copay	$10 Copay
Medical Pharmacy In-Network Provider / Out-of-Network Provider	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max	$200 In-Network Monthly Member OOP Max	$200 In-Network Monthly Member OOP Max
Preventive Care			
Routine Adult Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / 50% Coins
Mammograms In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0
Routine Child Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / 50% Coins	$0 / 50% Coins	$0 / 50% Coins
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.			
In-Network			
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	$1,500 Brand	$1,500 Brand	$800 Brand
Generic/Brand/Non-preferred	$10 / $60 / $100	$10 / $60 / $100	$10 / $60 / $100
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / $150 / $250	$25 / $150 / $250	$25 / $150 / $250
Out-of-Network			
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	$1,500 Brand	$1,500 Brand	$800 Brand
Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Emergency Medical Care			
Urgent Care Centers In-Network / Out-of-Network	$100 Copay / DED + 50% Coins	$100 Copay / DED + 50% Coins	$60 Copay / DED + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins	DED / DED
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED + 20% Coins	In-Network DED + 20% Coins	In-Network DED
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
In-Network Diagnostic Services (except AIS)	$75 Copay	$75 Copay	$75 Copay
In-NetworkAdvanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$200 Copay	$200 Copay	$250 Copay
Out-of-Network	DED + 50% Coins	DED + 50% Coins	DED + 50% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)			
In-Network (Option 1 / Option 2) / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED / DED + 50% Coins
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins	In-Network DED
Radiology, Pathology and Anesthesiology Provider Services at an ASC			
In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins	In-Network DED
Provider Services at Locations other than Office, Hospital and ER			
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED / DED + 50% Coins
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	40 Visits PCY	40 Visits PCY	10 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY	60 Days PCY	60 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical			
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED / DED + 50% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED / DED + 50% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services		(per admission) (PCY) Limit 21 Days	
In-Network (Option 1/Option 2) / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED / PAD + DED + 50% Coins
Outpatient Hospital Facility Services (per visit)			
In-Network - Therapy Services (Option 1 / Option 2)	$55 Copay / $75 Copay	$55 Copay / $75Copay	$55 Copay / $70Copay
In-Network - All Other Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins	DED
Out-of-Network	DED + 50% Coins	DED + 50% Coins	DED + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins	DED / DED
Financial Features			
Deductible (DED) (per person/family aggregate)			
In-Network	$2,500 / Not Applicable	$3,500 / Not Applicable	$1,500 / Not Applicable
Out-of-Network	$4,500 / $7,500	$5,500 / $8,500	$3,500 / Not Applicable
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$0	$0	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 50%	20% / 50%	0% / 50%
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	$6,000 / $12,000	$7,000 / $14,000	$1,500 / Not Applicable
Out-of-Network	$25,000 / $25,000	$25,000 / $25,000	$5,500 / Not Applicable
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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BlueOptions

COST SHARING (amount member pays)	Predictable Cost Plans Plan 530	Plan 531	Plan 532
Office Services			
Physician Office Services			
In-Network Family Physician / In-Network Specialist	$40 Copay / $75 Copay	$50 Copay / $85 Copay	$60 Copay / $85 Copay
Out-of-Network Office Visit / e-Office Visit	DED[1] + 50% Coins[2]	DED + 50% Coins	DED + 50% Coins
In-Network e-Office Visit (Family Physician / Specialist)	$40 Copay / $75 Copay	$50 Copay / $85 Copay	$60 Copay / $85 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	$300 Copay	$300 Copay	$300 Copay
Maternity (Rider available with certain plans)	Available	Available	Available
Allergy Injections (per visit) In-Network Family Physician	$10 Copay	$10 Copay	$10 Copay
Medical Pharmacy In-Network Provider / Out-of-Network Provider	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max	$200 In-Network Monthly Member OOP Max	$200 In-Network Monthly Member OOP Max
Preventive Care			
Routine Adult Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Mammograms In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Routine Child Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / 50% Coins	$0 / 50% Coins	$0 / 50% Coins
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.			
In-Network			
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	$1,500 Brand	$1,500 Brand	$1,500 Brand
Generic/Brand/Non-preferred	$10 / $60 / $100	$10 / $60 / $100	$10 / $60 / $100
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / $150 / $250	$25 / $150 / $250	$25 / $150 / $250
Out-of-Network			
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	$1,500 Brand	$1,500 Brand	$1,500 Brand
Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Emergency Medical Care			
Urgent Care Centers In-Network / Out-of-Network	$100 Copay / DED + 50% Coins	$100 Copay / DED + 50% Coins	$100 Copay / DED + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED + 20% Coins	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
In-Network Diagnostic Services (except AIS)	$75 Copay	$75 Copay	$75 Copay
In-NetworkAdvanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$200 Copay	$200 Copay	$200 Copay
Out-of-Network	DED + 50% Coins	DED + 50% Coins	DED + 50% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)			
In-Network (Option 1 / Option 2) / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC			
In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Provider Services at Locations other than Office, Hospital and ER			
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	45 Visits PCY	45 Visits PCY	45 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	45 Days PCY	45 Days PCY	45 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical			
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services		(per admission) (PCY) Limit 21 Days	
In-Network (Option 1/Option 2) / Out-of-Network	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Outpatient Hospital Facility Services (per visit)			
In-Network - Therapy Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins	DED + 20% Coins
In-Network - All Other Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins	DED + 20% Coins
Out-of-Network	DED + 50% Coins	DED + 50% Coins	DED + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Financial Features			
Deductible (DED) (per person/family aggregate)			
In-Network	$5,000 / $10,000	$7,500 / $15,000	$10,000 / $20,000
Out-of-Network	$10,0000 / $20,000	$15,000 / $30,000	$20,000 / $40,000
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 50%	20% / 50%	20% / 50%
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	$10,0000 / $20,000	$15,000 / $25,000	$20,000 / $30,000
Out-of-Network	$25,000 / $30,000	$25,000 / $35,000	$25,000 / $45,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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BlueOptions	Predictable Cost Plans		
COST SHARING (amount member pays)	**Plan 533**	**Plan 534**	**Plan 535**
Office Services			
Physician Office Services			
In-Network Family Physician / In-Network Specialist	$40 Copay / $75 Copay	$50 Copay / $85 Copay	$60 Copay / $85 Copay
Out-of-Network Office Visit / e-Office Visit	DED[1] + 50% Coins[2]	DED + 50% Coins	DED + 50% Coins
In-Network e-Office Visit (Family Physician / Specialist)	$40 Copay / $75 Copay	$50 Copay / $85 Copay	$60 Copay / $85 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	$300 Copay	$300 Copay	$300 Copay
Maternity (Rider available with certain plans)	Available	Available	Available
Allergy Injections (per visit) In-Network Family Physician	$10 Copay	$10 Copay	$10 Copay
Medical Pharmacy In-Network Provider / Out-of-Network Provider	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections	$300 In-Network Monthly Member OOP Max	$300 In-Network Monthly Member OOP Max	$300 In-Network Monthly Member OOP Max
Preventive Care			
Routine Adult Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Mammograms In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Routine Child Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / 50% Coins	$0 / 50% Coins	$0 / 50% Coins
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.			
In-Network			
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	$1,500 Brand	$1,500 Brand	$1,500 Brand
Generic/Brand/Non-preferred	$10 / $60 / $100	$10 / $60 / $100	$10 / $60 / $100
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / $150 / $250	$25 / $150 / $250	$25 / $150 / $250
Out-of-Network			
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	$1,500 Brand	$1,500 Brand	$1,500 Brand
Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Emergency Medical Care			
Urgent Care Centers In-Network / Out-of-Network	$100 Copay / DED + 50% Coins	$100 Copay / DED + 50% Coins	$100 Copay / DED + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network DED	In-Network DED	In-Network DED
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED	In-Network DED	In-Network DED
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
In-Network Diagnostic Services (except AIS)	$75 Copay	$75 Copay	$75 Copay
In-NetworkAdvanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$200 Copay	$200 Copay	$200 Copay
Out-of-Network	DED + 50% Coins	DED + 50% Coins	DED + 50% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)			
In-Network (Option 1 / Option 2) / Out-of-Network	DED / DED + 50% Coins	DED / DED + 50% Coins	DED / DED + 50% Coins
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED	In-Network DED	In-Network DED
Radiology, Pathology and Anesthesiology Provider Services at an ASC			
In-Network / Out-of-Network	In-Network DED	In-Network DED	In-Network DED
Provider Services at Locations other than Office, Hospital and ER			
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED / DED + 50% Coins	DED / DED + 50% Coins	DED / DED + 50% Coins
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	45 Visits PCY	45 Visits PCY	45 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	45 Days PCY	45 Days PCY	45 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical			
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	DED / DED + 50% Coins	DED / DED + 50% Coins	DED / DED + 50% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED / DED + 50% Coins	DED / DED + 50% Coins	DED / DED + 50% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services		(per admission) (PCY) Limit 21 Days	
In-Network (Option 1/Option 2) / Out-of-Network	DED / DED + 50% Coins	DED / DED + 50% Coins	DED / DED + 50% Coins
Outpatient Hospital Facility Services (per visit)			
In-Network - Therapy Services (Option 1 / Option 2)	DED	DED	DED
In-Network - All Other Services (Option 1 / Option 2)	DED	DED	DED
Out-of-Network	DED + 50% Coins	DED + 50% Coins	DED + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network DED	In-Network DED	In-Network DED
Financial Features			
Deductible (DED) (per person/family aggregate)			
In-Network	$5,000 / $10,000	$7,500 / $15,000	$10,000 / $20,000
Out-of-Network	$10,000 / $20,000	$15,000 / $30,000	$20,000 / $40,000
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	0% / 50%	0% / 50%	0% / 50%
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	$5,0000 / $10,000	$7,500 / $15,000	$10,000 / $20,000
Out-of-Network	$25,000 / $30,000	$25,000 / $35,000	$25,000 / $45,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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COST SHARING (amount member pays)	Lower Premium Plans	
	Plan 570	**Plan 571**
Office Services		
Physician Office Services (Surgical Services Only)		
In-Network Family Physician / In-Network Specialist	DED[1] + 20% Coins[2]	DED + 20% Coins
Out-of-Network Office Visit / e-Office Visit	DED + 40% Coins	DED + 40% Coins
In-Network e-Office Visit (Family Physician / Specialist)	$10 Copay	$10 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) (Surgical Services Only) In-Network	DED + 20% Coins	DED + 20% Coins
Maternity (Rider available with certain plans)	Not Available	Not Available
Allergy Injections (per visit) In-Network Family Physician	Not Covered	Not Covered
Medical Pharmacy (Applies if related to surgery) In-Network Provider / Out-of-Network Provider	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max	$200 In-Network Monthly Member OOP Max
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	$0 / 40% Coins	$0 / 40% Coins
Mammograms	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.		
In-Network		
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	Not Applicable	Not Applicable
Generic/Brand/Non-preferred	Access to Discounts	Access to Discounts
Mail Order (90 days) - Generic/Brand/Non-preferred	Access to Discounts	Access to Discounts
Out-of-Network		
Pharmacy Deductible ***Rx Deductible is combined INN & OON & applies to Mail Order***	Not Applicable	Not Applicable
Generic/Brand/Non-preferred	Not Covered	Not Covered
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered	Not Covered
Emergency Medical Care		
Urgent Care Centers (Surgical Services Only) In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit)	DED + 20% Coins / DED + 20% Coins	DED + 20% Coins / DED + 20% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel (Surgical Services Only)	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services) (Services Related to Surgery)		
In-Network Diagnostic Services (except AIS)	DED + 20% Coins	DED + 20% Coins
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	DED + 20% Coins	DED + 20% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
Independent Clinical Lab (e.g., blood work) (Related to Surgery Only) In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (Services Related to Surgery)		
In-Network (Option 1 / Option 2) / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Mental Health / Substance Abuse		
Mental Health	Not Covered	Not Covered
Substance Dependency	Not Covered	Not Covered
Other Provider Services		
Provider Services at Hospital and ER (If admitted or if a Surgical Service is performed) In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC (Services Related to Surgery)		
In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Provider Services at Locations other than Office, Hospital and ER (Services Related to Surgery)		
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations	Not Covered	Not Covered
Home Health Care	Not Covered	Not Covered
Skilled Nursing Facility	Not Covered	Not Covered
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC) (Surgical Services Only) In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Provider Services Rendered at an ASC (Surgeon) (Surgical Services Only) In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY[5]) Limit 21 Days	
In-Network (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
Out-of-Network	PAD + DED + 40% Coins	PAD + DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (Surgical Services Only)		
In-Network - Therapy Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
In-Network - All Other Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
ER Facility Services (per visit) In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit)	DED + 20% Coins / DED + 20% Coins	DED + 20% Coins / DED + 20% Coins
Financial Features		
Deductible (DED) (per person/family aggregate)		
In-Network	$250 / Not Applicable	$1,000 / Not Applicable
Out-of-Network	$750 / Not Applicable	$1,500 / Not Applicable
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500
Emergency Room Per Visit Deductible (PVD) (applies INN and OON for Non Surgical Services w/o admit)	$2,500	$2,500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 40%	20% / 40%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$2,500 / Not Applicable	$5,000 / Not Applicable
Out-of-Network	$5,000 / Not Applicable	$10,000 / Not Applicable
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.
[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida Inc. This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc. This matrix does not constitute a Contract.

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Florida Blue

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COST SHARING (amount member pays)	Lower Premium Plans	
	Plan 572	**Plan 573**
Office Services		
Physician Office Services (Surgical Services Only)		
In-Network Family Physician / In-Network Specialist	DED[1] + 20% Coins[2]	DED + 20% Coins
Out-of-Network Office Visit / e-Office Visit	DED + 40% Coins	DED + 40% Coins
In-Network e-Office Visit (Family Physician / Specialist)	$10 Copay	$10 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) (Surgical Services Only) In-Network	DED + 20% Coins	DED + 20% Coins
Maternity (Rider available with certain plans)	Not Available	Not Available
Allergy Injections (per visit) In-Network Family Physician	Not Covered	Not Covered
Medical Pharmacy (Applies if related to surgery) In-Network Provider / Out-of-Network Provider	20% Coins / DED + 50% Coins	20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max	$200 In-Network Monthly Member OOP Max
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	$0 / 40% Coins	$0 / 40% Coins
Mammograms	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.		
In-Network		
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	Not Applicable	Not Applicable
Generic/Brand/Non-preferred	Access to Discounts	Access to Discounts
Mail Order (90 days) - Generic/Brand/Non-preferred	Access to Discounts	Access to Discounts
Out-of-Network		
Pharmacy Deductible ***Rx Deductible is combined INN & OON & applies to Mail Order***	Not Applicable	Not Applicable
Generic/Brand/Non-preferred	Not Covered	Not Covered
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered	Not Covered
Emergency Medical Care		
Urgent Care Centers (Surgical Services Only) In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit)	DED + 20% Coins / DED + 20% Coins	DED + 20% Coins / DED + 20% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel (Surgical Services Only)	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services) (Services Related to Surgery)		
In-Network Diagnostic Services (except AIS)	DED + 20% Coins	DED + 20% Coins
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	DED + 20% Coins	DED + 20% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
Independent Clinical Lab (e.g., blood work) (Related to Surgery Only) In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (Services Related to Surgery)		
In-Network (Option 1 / Option 2) / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Mental Health / Substance Abuse		
Mental Health	Not Covered	Not Covered
Substance Dependency	Not Covered	Not Covered
Other Provider Services		
Provider Services at Hospital and ER (If admitted or if a Surgical Service is performed) In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC (Services Related to Surgery)		
In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Provider Services at Locations other than Office, Hospital and ER (Services Related to Surgery)		
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations	Not Covered	Not Covered
Home Health Care	Not Covered	Not Covered
Skilled Nursing Facility	Not Covered	Not Covered
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC) (Surgical Services Only) In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Provider Services Rendered at an ASC (Surgeon) (Surgical Services Only) In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY[5]) Limit 21 Days	
In-Network (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
Out-of-Network	PAD + DED + 40% Coins	PAD + DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (Surgical Services Only)		
In-Network - Therapy Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
In-Network - All Other Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
ER Facility Services (per visit) In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit)	DED + 20% Coins / DED + 20% Coins	DED + 20% Coins / DED + 20% Coins
Financial Features		
Deductible (DED) (per person/family aggregate)		
In-Network	$2,500 / Not Applicable	$5,000 / $5,000
Out-of-Network	$5,000 / Not Applicable	$10,000 / $10,000
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500
Emergency Room Per Visit Deductible (PVD) (applies INN and OON for Non Surgical Services w/o admit)	$2,500	$2,500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 40%	20% / 40%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$5,000 / Not Applicable	$10,000 / $10,000
Out-of-Network	$25,000 / Not Applicable	$25,000 / $25,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.
[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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COST SHARING (amount member pays)	High-Deductible Plans (HSA Compatible) Plans 622 / 623 Single / Family	Plans 624 / 625 Single / Family
Office Services		
Physician Office Services		
In-Network Family Physician / In-Network Specialist	DED[1]	DED
Out-of-Network Office Visit / e-Office Visit	DED + 20% Coins[2]	DED + 20% Coins
In-Network e-Office Visit (Family Physician / Specialist)	DED	DED
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	DED	DED
Maternity (Rider available with certain plans)	Not Available	Not Available
Allergy Injections (per visit) In-Network Family Physician	DED	DED
Medical Pharmacy In-Network Provider / Out-of-Network Provider	DED / DED + 50% Coins	DED / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	In-Network Monthly Member OOP Max does not apply	In-Network Monthly Member OOP Max does not apply
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	$0 / 20% Coins	$0 / 20% Coins
Mammograms	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.		
In-Network		
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	Health Plan INN DED	Health Plan INN DED
Generic/Brand/Non-preferred	100% after INN DED	100% after INN DED
Mail Order (90 days) - Generic/Brand/Non-preferred	100% after INN DED	100% after INN DED
Out-of-Network		
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	Health Plan INN DED	Health Plan INN DED
Generic/Brand/Non-preferred	50% Coins after INN DED	50% Coins after INN DED
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins after INN DED	50% Coins after INN DED
Emergency Medical Care		
Urgent Care Centers In-Network / Out-of-Network	DED / DED + 20% Coins	DED / DED + 20% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED / DED	DED / DED
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED	In-Network DED
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)		
In-Network Diagnostic Services (except AIS)	DED	DED
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	DED	DED
Out-of-Network	DED + 20% Coins	DED + 20% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	DED / DED + 20% Coins	DED / DED + 20% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)		
In-Network (Option 1 / Option 2) / Out-of-Network	DED / DED + 20% Coins	DED / DED + 20% Coins
Mental Health / Substance Abuse		
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum
Other Provider Services		
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED	In-Network DED
Radiology, Pathology and Anesthesiology Provider Services at an ASC		
In-Network / Out-of-Network	In-Network DED	In-Network DED
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED / DED + 20% Coins	DED / DED + 20% Coins
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	20 Visits PCY	20 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY	60 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	DED / DED + 20% Coins	DED / DED + 20% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED / DED + 20% Coins	DED / DED + 20% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days	
In-Network (Option 1 / Option 2)	DED	DED
Out-of-Network	PAD + DED + 20% Coins	PAD + DED + 20% Coins
Outpatient Hospital Facility Services (per visit)		
In-Network - Therapy Services (Option 1 / Option 2)	DED	DED
In-Network - All Other Services (Option 1 / Option 2)	DED	DED
Out-of-Network	DED + 20% Coins	DED + 20% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED / DED	DED / DED
Financial Features		
Deductible (DED) (per person/family aggregate)		
In-Network	$2,500/NA $5,000/$5,000	$3,500/NA $7,000/$7,000
Out-of-Network	$5,000/NA $10,000/$10,000	$7,000/NA $14,000/$14,000
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	0% / 20%	0% / 20%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$2,500/NA $5,000/$5,000	$3,500/NA $7,000/$7,000
Out-of-Network	$10,000/NA $20,000/$20,000	$14,000/NA $28,000/$28,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

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BlueOptions	High-Deductible Plans (HSA Compatible)		
COST SHARING (amount member pays)	**Plans 626 / 627 Single / Family**	**Plan 630 Single**	**Plan 632 Single**
Office Services			
Physician Office Services			
In-Network Family Physician / In-Network Specialist	DED[1]	DED	DED
Out-of-Network Office Visit / e-Office Visit	DED + 40% Coins[2]	DED + 20% Coins	DED + 20% Coins
In-Network e-Office Visit (Family Physician / Specialist)	DED	DED	DED
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	DED	DED	DED
Maternity (Rider available with certain plans)	Not Available	Not Available	Not Available
Allergy Injections (per visit) In-Network Family Physician	DED	DED	DED
Medical Pharmacy In-Network Provider / Out-of-Network Provider	DED / DED + 50% Coins	DED / DED + 50% Coins	DED / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy	In-Network Monthly Member OOP Max does not apply	In-Network Monthly Member OOP Max does not apply	In-Network Monthly Member OOP Max does not apply
Preventive Care			
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / 40% Coins	$0 / 20% Coins	$0 / 20% Coins
Mammograms	$0	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.			
In-Network			
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	Health Plan INN DED	Health Plan INN DED	Not Applicable
Generic/Brand/Non-preferred	100% after INN DED	$10 / $60 / $100	Access to Discounts
Mail Order (90 days) - Generic/Brand/Non-preferred	100% after INN DED	$25 / $150 / $250	Access to Discounts
Out-of-Network			
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	Health Plan INN DED	Health Plan INN DED	Not Applicable
Generic/Brand/Non-preferred	50% Coins after INN DED	50% Coins after INN DED	Not Covered
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins after INN DED	50% Coins after INN DED	Not Covered
Emergency Medical Care			
Urgent Care Centers In-Network / Out-of-Network	DED / DED + 40% Coins	DED / DED + 20% Coins	DED / DED + 20% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED / DED	DED / DED	DED / DED
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED	In-Network DED	In-Network DED
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
In-Network Diagnostic Services (except AIS)	DED	DED	DED
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	DED	DED	DED
Out-of-Network	DED + 40% Coins	DED + 20% Coins	DED + 20% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	DED / DED + 40% Coins	DED / DED + 20% Coins	DED / DED + 20% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)			
In-Network (Option 1 / Option 2) / Out-of-Network	DED / DED + 40% Coins	DED / DED + 20% Coins	DED / DED + 20% Coins
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED	In-Network DED	In-Network DED
Radiology, Pathology and Anesthesiology Provider Services at an ASC			
In-Network / Out-of-Network	In-Network DED	In-Network DED	In-Network DED
Provider Services at Locations other than Office, Hospital and ER			
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED / DED + 40% Coins	DED / DED + 20% Coins	DED / DED + 20% Coins
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	20 Visits PCY	20 Visits PCY	20 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY	60 Days PCY	60 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical			
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	DED / DED + 40% Coins	DED / DED + 20% Coins	DED / DED + 20% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED / DED + 40% Coins	DED / DED + 20% Coins	DED / DED + 20% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days		
In-Network (Option 1 / Option 2)	DED	DED	DED
Out-of-Network	PAD + DED + 40% Coins	PAD + DED + 20% Coins	PAD + DED + 20% Coins
Outpatient Hospital Facility Services (per visit)			
In-Network - Therapy Services (Option 1 / Option 2)	DED	DED	DED
In-Network - All Other Services (Option 1 / Option 2)	DED	DED	DED
Out-of-Network	DED + 40% Coins	DED + 20% Coins	DED + 20% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED / DED	DED / DED	DED / DED
Financial Features			
Deductible (DED) (per person/family aggregate)			
In-Network	$5,000/NA $10,000/$10,000	$1,500 / Not Applicable	$1,500 / Not Applicable
Out-of-Network	$10,000/NA $20,000/$20,000	$3,000 / Not Applicable	$3,000 / Not Applicable
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	0% / 40%	0% / 20%	0% / 20%
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	$5,000/NA $10,000/$10,000	$3,000 / Not Applicable	$1,500 / Not Applicable
Out-of-Network	$25,000/NA $25,000/$25,000	$6,000 / Not Applicable	$3,000 / Not Applicable
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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BlueOptions	High-Deductible Plans (HSA Compatible)	
	Plans 640 / 641 Single / Family	**Plans 642 / 643 Single / Family**
COST SHARING (amount member pays)		
Office Services		
Physician Office Services		
In-Network Family Physician / In-Network Specialist	DED[1] + 10% Coins[2]	DED + 10% Coins
Out-of-Network Office Visit / e-Office Visit	DED + 40% Coins	DED + 40% Coins
In-Network e-Office Visit (Family Physician / Specialist)	DED + 10% Coins	DED + 10% Coins
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	DED + 10% Coins	DED + 10% Coins
Maternity (Rider available with certain plans)	Not Available	Not Available
Allergy Injections (per visit) In-Network Family Physician	DED + 10% Coins	DED + 10% Coins
Medical Pharmacy In-Network Provider / Out-of-Network Provider	DED + 20% Coins / DED + 50% Coins	DED + 20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max after In-Network DED is met	$200 In-Network Monthly Member OOP Max after In-Network DED is met
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	$0 / 40% Coins	$0 / 40% Coins
Mammograms	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.		
In-Network		
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	Health Plan INN DED	Health Plan INN DED
Generic/Brand/Non-preferred	$10 / $50 / $80	$10 / $50 / $80
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / $125 / $200	$25 / $125 / $200
Out-of-Network		
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	Health Plan INN DED	Health Plan INN DED
Generic/Brand/Non-preferred	50% Coins after INN DED	50% Coins after INN DED
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins after INN DED	50% Coins after INN DED
Emergency Medical Care		
Urgent Care Centers In-Network / Out-of-Network	DED + 10% Coins / DED + 40% Coins	DED + 10% Coins / DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED + 10% Coins / DED + 10% Coins	DED + 10% Coins / DED + 10% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED + 10% Coins	In-Network DED + 10% Coins
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)		
In-Network Diagnostic Services (except AIS)	DED + 10% Coins	DED + 10% Coins
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	DED + 10% Coins	DED + 10% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	DED + 10% Coins / DED + 40% Coins	DED + 10% Coins / DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)		
In-Network (Option 1 / Option 2) / Out-of-Network	DED + 10% Coins / DED + 40% Coins	DED + 10% Coins / DED + 40% Coins
Mental Health / Substance Abuse		
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum
Other Provider Services		
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED + 10% Coins	In-Network DED + 10% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC		
In-Network / Out-of-Network	In-Network DED + 10% Coins	In-Network DED + 10% Coins
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 10% Coins / DED + 40% Coins	DED + 10% Coins / DED + 40% Coins
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	20 Visits PCY	20 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY	60 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	DED + 10% Coins /DED + 40% Coins	DED + 10% Coins / DED + 40% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED + 10% Coins / DED + 40% Coins	DED + 10% Coins / DED + 40% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days	
In-Network (Option 1 / Option 2)	DED + 10% Coins	DED + 10% Coins
Out-of-Network	PAD + DED + 40% Coins	PAD + DED + 40% Coins
Outpatient Hospital Facility Services (per visit)		
In-Network - Therapy Services (Option 1 / Option 2)	DED + 10% Coins	DED + 10% Coins
In-Network - All Other Services (Option 1 / Option 2)	DED + 10% Coins	DED + 10% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED + 10% Coins / DED + 10% Coins	DED + 10% Coins / DED + 10% Coins
Financial Features		
Deductible (DED) (per person/family aggregate)		
In-Network	$1,500/NA $3,000 / $3,000	$2,500/NA $5,000 / $5,000
Out-of-Network	$3,000/NA $6,000 / $6,000	$5,000/NA $10,000 / $10,000
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	10% / 40%	10% / 40%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$3,000/NA $6,000/$6,000	$5,000/NA $10,000/$10,000
Out-of-Network	$6,000/NA $12,000/$12,000	$10,000/NA $20,000/$20,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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BlueOptions	High-Deductible Plans (HSA Compatible)	
	Plans 660 / 661 Single / Family	**Plans 662 / 663 Single / Family**
COST SHARING (amount member pays)		
Office Services		
Physician Office Services		
In-Network Family Physician / In-Network Specialist	DED[1] + 20% Coins[2]	DED + 20% Coins
Out-of-Network Office Visit / e-Office Visit	DED + 40% Coins	DED + 40% Coins
In-Network e-Office Visit (Family Physician / Specialist)	DED + 20% Coins	DED + 20% Coins
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	DED + 20% Coins	DED + 20% Coins
Maternity (Rider available with certain plans)	Not Available	Not Available
Allergy Injections (per visit) In-Network Family Physician	DED + 20% Coins	DED + 20% Coins
Medical Pharmacy In-Network Provider / Out-of-Network Provider	DED + 20% Coins / DED + 50% Coins	DED + 20% Coins / DED + 50% Coins
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max after In-Network DED is met	$200 In-Network Monthly Member OOP Max after In-Network DED is met
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	$0 / 40% Coins	$0 / 40% Coins
Mammograms	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.		
In-Network		
Pharmacy Deductible ***Rx Deductible is combined INN[3] & OON[4] and applies to Mail Order***	Health Plan INN DED	Health Plan INN DED
Generic/Brand/Non-preferred	$10 / $50 / $80	$10 / $50 / $80
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / $125 / $200	$25 / $125 / $200
Out-of-Network		
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	Health Plan INN DED	Health Plan INN DED
Generic/Brand/Non-preferred	50% Coins after INN DED	50% Coins after INN DED
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins after INN DED	50% Coins after INN DED
Emergency Medical Care		
Urgent Care Centers In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED + 20% Coins / DED + 20% Coins	DED + 20% Coins / DED + 20% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)		
In-Network Diagnostic Services (except AIS)	DED + 20% Coins	DED + 20% Coins
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	DED + 20% Coins	DED + 20% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)		
In-Network (Option 1 / Option 2) / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Mental Health / Substance Abuse		
Mental Health (Inpatient PCY[5] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum
Other Provider Services		
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC		
In-Network / Out-of-Network	In-Network DED + 20% Coins	In-Network DED + 20% Coins
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician or In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	20 Visits PCY	20 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY	60 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	DED + 20% Coins /DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	DED + 20% Coins / DED + 40% Coins	DED + 20% Coins / DED + 40% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days	
In-Network (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
Out-of-Network	PAD + DED + 40% Coins	PAD + DED + 40% Coins
Outpatient Hospital Facility Services (per visit)		
In-Network - Therapy Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
In-Network - All Other Services (Option 1 / Option 2)	DED + 20% Coins	DED + 20% Coins
Out-of-Network	DED + 40% Coins	DED + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	DED + 20% Coins / DED + 20% Coins	DED + 20% Coins / DED + 20% Coins
Financial Features		
Deductible (DED) (per person/family aggregate)		
In-Network	$1,500/NA $3,000 / $3,000	$2,500/NA $5,000 / $5,000
Out-of-Network	$3,000/NA $6,000 / $6,000	$5,000/NA $10,000 / $10,000
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 40%	20% / 40%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$4,500/NA $9,000/$9,000	$5,800/NA $11,600/$11,600
Out-of-Network	$9,000/NA $18,000/$18,000	$11,600/NA $23,200/$23,200
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[2] Coins = Percentage based on our Allowed Amount [3] INN = In-Network [4] OON = Out-of-Network [5] PCY = Per Calendar Year

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BlueOptions **Free Quote Call 352-200-2066 Now!**	Health Plans with Dental		
COST SHARING (amount member pays)	**Plan 598**	**Plan 700 Hospital Surgical Plus**	**Plan 704 Hospital Surgical Plus**
Office Services			
Physician Office Services			
In-Network Family Physician / In-Network Specialist	$35 Copay / $50 Copay	$50/Balance[1] / $75/Balance	$50/Balance
Out-of-Network Office Visit / e-Office Visit	DED[2] + 50% Coins[3]	$50/Balance	$50/Balance
In-Network e-Office Visit (Family Physician / Specialist)	$10 Copay	$50/Balance / $75/Balance	$50/Balance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)			
In-Network Family Physician / In-Network Specialist	$200 Copay	$50/Balance / $75/Balance	$50/Balance
Maternity (Rider available with certain plans)	Available	Available	Available
Allergy Injections (per visit) In-Network Family Physician / In-Network Specialist	$10 Copay	$50/Balance / $75/Balance	$50 / Balance
Medical Pharmacy In-Network Provider / Out-of-Network Provider	20% Coins / DED + 50% Coins	Not Applicable	
(Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	$200 In-Network Monthly Member OOP Max	Included in Office Services Benefit. No separate member cost share for this benefit on these plans.	
Preventive Care			
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / 50% Coins	$0 / $50/Balance	$0 / $50/Balance
Mammograms In-Network / Out-of-Network	$0	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	$0	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.			
In-Network			
Pharmacy Deductible ***Rx Deductible is combined INN[4] & OON[5] and applies to Mail Order***	$0	$800 Brand	$800 Brand
Generic/Brand/Non-preferred	$10 / Not Covered	$10 / $60 / $100	$10 / $60 / $100
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / Not Covered	$25 / $150 / $250	$25 / $150 / $250
Out-of-Network			
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	$0	$800 Brand	$800 Brand
Generic/Brand/Non-preferred	50% / Not Covered	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred	50% / Not Covered	50% Coins	50% Coins
Emergency Medical Care			
Urgent Care Centers In-Network / Out-of-Network	$55 Copay / DED + 50% Coins	$50/Balance	$50/Balance
Emergency Room Facility Services (ER) (per visit)			
In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit for Plans 700 and 704)	$300 Copay	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED + 25% Coins	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
In-Network Diagnostic Services (except AIS)	$50 Copay	$75 Copay	$75 Copay
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$200 Copay	$150 Copay	$250 Copay
Out-of-Network	DED + 50% Coins	DED + 50% Coins	DED + 50% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)			
In-Network (Option 1 / Option 2) / Out-of-Network	DED + 25% Coins/DED + 50% Coins	DED + 10% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY[6] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED + 25% Coins	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC In-Network & Out-of-Network	In-Network DED + 25% Coins	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Provider Services at Locations other than Office, Hospital and ER			
In-Network Family Physician / In-Network Specialist	DED + 25% Coins	$50/Balance / $75/Balance	$50/Balance
Out-of-Network	DED + 40% Coins	$50/Balance	$50/Balance
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	35 Visits PCY	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	10 Visits PCY	45 Visits PCY	45 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	60 Days PCY	45 Days PCY	45 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical			
Ambulatory Surgical Center Facility (ASC)			
In-Network / Out-of-Network (Surgical Services only for Plans 700 and 704)	DED + 25% Coins/DED + 50% Coins	DED + 10% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Provider Services Rendered at an ASC (Surgeon)			
In-Network Specialist / Out-of-Network (Surgical Services only for Plans 700 and 704)	DED + 25% Coins/DED + 50% Coins	$50/Balance / $75/Balance	$50/Balance
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days		
In-Network (Option 1 / Option 2)	DED + 25% Coins	DED + 10% Coins	DED + 20% Coins
Out-of-Network	PAD + DED + 50% Coins	PAD + DED + 50% Coins	PAD + DED + 50% Coins
Outpatient Hospital Facility Services (per visit)			
In-Network - Therapy Services (Option 1 / Option 2)	$55 Copay / $70 Copay	Not Covered	Not Covered
In-Network - All Other Services (Option 1 / Option 2) (Surgical Services only for Plans 700 and 704)	DED + 25% Coins	DED + 10% Coins	DED + 20% Coins
Out-of-Network (Surgical Services only for Plans 700 and 704)	DED + 50% Coins	DED + 50% Coins	DED + 50% Coins
Emergency Room Facility Services (ER) (per visit)			
In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit for Plans 700 and 704)	$300 Copay	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Dental Coverage			
Dental Preventive Services / Dental Basic Services	$0 / 20% Coins	$50/Balance / $50/Balance	$50/Balance / $50/Balance
In-Network Individual Dental Deductible (DED) (Per Person/Family Aggregate)(Out-of-Network combined w/INN)	$75 / $225	Not Applicable	Not Applicable
Dental Benefit Period Maximum	$750	Not Applicable	Not Applicable
Financial Features			
Deductible (DED) (per person/family aggregate)			
In-Network	$3,000 / Not Applicable	$250 / Not Applicable	$2,500 / Not Applicable
Out-of-Network	$6,000 / Not Applicable	$750 / Not Applicable	$5,000 / Not Applicable
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500	$700
Emergency Room Per Visit Deductible (PVD) (applies INN and OON for Non Surgical Services w/o admit)	Not Applicable	$500	$750
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	25% / 50%	10% / 50%	20% / 50%
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	$7,500 / $15,000	$2,500 / Not Applicable	$7,500 / Not Applicable
Out-of-Network	$25,000 / $25,000	$5,000 / Not Applicable	$15,000 / Not Applicable
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum

[1] Balance = BCBS pays the Amount indicated or the Allowed Amount (whichever is lower) and the Member pays the Balance up to the Allowed Amount.

[2] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[3] Coins = Percentage based on our Allowed Amount [4] INN = In-Network [5] OON = Out-of-Network [6] PCY = Per Calendar Year

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BlueOptions	Health Plans with Dental	
	Plan 706 Hospital Surgical Plus	Plan 710 Hospital Surgical Plus
COST SHARING (amount member pays)		
Office Services		
Physician Office Services		
In-Network Office Visit and e-Office Visit Family Physician / Specialist	$50/Balance[1] / $75/Balance	$50/Balance
Out-of-Network Office Visit / e-Office Visit	$50/Balance	$50/Balance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network Family Physician / In-Network Specialist	$50/Balance / $75/Balance	$50/Balance
Maternity (Rider available with certain plans)	Available	Available
Allergy Injections (per visit) In-Network Family Physician / In-Network Specialist	$50/Balance / $75/Balance	$50 / Balance
Medical Pharmacy Included in Office Services Benefit. No separate member cost share for this benefit on these plans.	Not Applicable	
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations In-Network / Out-of-Network	$0 / $50/Balance	$0 / $50/Balance
Mammograms In-Network / Out-of-Network	$0 / DED[2] + 50% Coins[3]	$0 / DED + 50% Coins
Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Prescription Drug Program Prescription Generic oral contraceptives & diaphragms are covered at no cost to the member.		
In-Network		
Pharmacy Deductible ***Rx Deductible is combined INN[4] & OON[5] and applies to Mail Order***	$0	$0
Generic/Brand/Non-preferred	$15/Balance	$15/Balance
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered	Not Covered
Out-of-Network		
Pharmacy Deductible ***Rx Deductible is combined INN & OON and applies to Mail Order***	$0	$0
Generic/Brand/Non-preferred	$15/Balance	$15/Balance
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered	Not Covered
Emergency Medical Care		
Urgent Care Centers In-Network / Out-of-Network	$50/Balance	$50/Balance
Emergency Room Facility Services (ER) (per visit)		
In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit)	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Ambulance Services (INN & OON); $5,500 per day max for combined ground, air & water travel	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)		
In-Network Diagnostic Services (except AIS)	$75 Copay	$75 Copay
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$150 Copay	$250 Copay
Out-of-Network	DED + 50% Coins	DED + 50% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / DED + 50% Coins	$0 / DED + 50% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) In-Network (Option 1 / Option 2) / Out-of-Network	DED + 10% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Mental Health / Substance Abuse		
Mental Health (Inpatient PCY[6] / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency	No Benefit Maximum	No Benefit Maximum
Other Provider Services		
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC In-Network & Out-of-Network	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician / In-Network Specialist	$50/Balance / $75/Balance	$50/Balance
Out-of-Network	$50/Balance	$50/Balance
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY
Home Health Care (subject to DED + Coins)	45 Visits PCY	45 Visits PCY
Skilled Nursing Facility (subject to DED + Coins)	45 Days PCY	45 Days PCY
Hospice (subject to DED + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network (Surgical Services only)	DED + 10% Coins/DED + 50% Coins	DED + 20% Coins/DED + 50% Coins
Provider Services Rendered at an ASC (Surgeon)		
In-Network Specialist / Out-of-Network (Surgical Services only)	$50/Balance / $75/Balance	$50/Balance
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services		
In-Network (Option 1 / Option 2)	DED + 10% Coins	DED + 20% Coins
Out-of-Network	PAD + DED + 50% Coins	PAD + DED + 50% Coins
Outpatient Hospital Facility Services (per visit)		
In-Network - Therapy Services (Option 1 / Option 2)	Not Covered	Not Covered
In-Network - All Other Services (Option 1 / Option 2) (Surgical Services only)	DED + 10% Coins	DED + 20% Coins
Out-of-Network (Surgical Services only)	DED + 50% Coins	DED + 50% Coins
Emergency Room Facility Services (ER) (per visit)		
In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit)	In-Network DED + 10% Coins	In-Network DED + 20% Coins
Dental Coverage		
Dental Preventive Services / Dental Basic Services	$50/Balance	$50/Balance
Financial Features		
Deductible (DED) (per person/family aggregate)		
In-Network	$250 / Not Applicable	$2,500 / Not Applicable
Out-of-Network	$750 / Not Applicable	$5,000 / Not Applicable
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$700
Emergency Room Per Visit Deductible (PVD) (applies INN and OON for Non Surgical Services w/o admit)	$500	$750
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	10% / 50%	20% / 50%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$2,500 / Not Applicable	$7,500 / Not Applicable
Out-of-Network	$5,000 / Not Applicable	$15,000 / Not Applicable
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] Balance = BCBS pays the Amount indicated or the Allowed Amount (whichever is lower) and the Member pays the Balance up to the Allowed Amount.

[2] DED (Deductible) = The fixed dollar amount that must be paid in a calendar year for covered health care expenses before insurance begins to pay.

[3] Coins = Percentage based on our Allowed Amount [4] INN = In-Network [5] OON = Out-of-Network [6] PCY = Per Calendar Year

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