Small Group - BlueOptions Enhanced Consumer Choice Plans

Cost Sharing		5461 Predictable Cost	5462 Predictable Cost	5463 Predictable Cost	5464 Predictable Cost	5465 Predictable Cost
Physician Office Services	In-Network Family Physician	$10 Copayment	$15 Copayment	$25 Copayment	$30 Copayment	$20 Copayment
	In-Network Specialist	$25 Copayment	$35 Copayment	$50 Copayment	$60 Copayment	$45 Copayment
	In-Network e-Office Visit	$10 Copayment	$10 Copayment	$10 Copayment	$10 Copayment	$10 Copayment
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$75 Copayment	$150 Copayment	$100 Copayment	$250 Copayment	$200 Copayment
	Out-of-Network Provider	DED[1] + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Medical Pharmacy (Applies to Office Setting & Specialty Pharmacy Vendors)	In-Network Monthly Out-of-Pocket Maximum[2]	$200	$200	$200	$200	$200
	In-Network Provider	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
	Out of Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Emergency Room Facility Services (per visit; copayment waived if admitted)	In-Network	$100 Copayment	$100 Copayment	$100 Copayment	$250 Copayment	$150 Copayment
	Out-of-Network	$200 Copayment	$200 Copayment	$200 Copayment	DED + 50% Coinsurance	DED + 50% Coinsurance
Independent Diagnostic Testing Facility Services (Fac./Phy. Charges billes as one bill)	In-Network	$50 Copayment	$50 Copayment	$50 Copayment	$50 Copayment	$50 Copayment
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$75 Copayment	$150 Copayment	$100 Copayment	$250 Copayment	$200 Copayment
	Out-of-Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Independent Clinical Lab	In-Network	$0	$0	$0	$0	$0
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Provider Services at Hospital and ER	In-Network and Out-of-Network	$50 Copayment	$50 Copayment	$50 Copayment	In-Network DED	In-Network DED + 20% Coinsurance
Physician Services at Locations other than Office, Hosptial, and Emergency Room	In-Network Family Physician	$10 Copayment	$15 Copayment	$15 Copayment	DED	$20 Copayment
	In-Network Specialist	$25 Copayment	$35 Copayment	$35 Copayment	DED	$45 Copayment
	Out-of-Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Ambulatory Surgical Center Facility	In-Network	$75 Copayment	$100 Copayment	$100 Copayment	DED	$200 Copayment
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Inpatient Hospital Facility Services (per admission)	In-Network					
	Option 1	$250 Copayment	$600 Copayment	DED + 20% Coinsurance	DED	$800 Copayment
	Option 2	$375 Copayment	$1,000 Copayment	DED + 20% Coinsurance	DED	$1,200 Copayment
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Outpatient Hospital Facility Services (per visit)	In-Network - Therapy Services					
	Option 1	$40 Copayment	$40 Copayment	$55 Copayment	$65 Copayment	$50 Copayment
	Option 2	$50 Copayment	$50 Copayment	$65 Copayment	$75 Copayment	$60 Copayment
	In-Network - All Other Services					
	Option 1	$100 Copayment	$250 Copayment	DED + 20% Coinsurance	DED	$350 Copayment
	Option 2	$150 Copayment	$350 Copayment	DED + 20% Coinsurance	DED	$450 Copayment
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Deductible[3] (per Person / Family Aggregate)	In-Network	$250 / $750	$500 / $1,500	$500 / $1,500	$2,000 / $6,000	$1,000 / $3,000
	Out-of-Network	$1,000 / $3,000	$1,000 / $3,000	$1,000 / $3,000	$4,000 / $12,000	$6,000 / $8,000
Coinsurance (amount member pays)	In-Network	10%	20%	20%	0%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Out-of-Pocket Maximum[3] (per Person / Family Aggregate)	In-Network	$2,000 / $4,000	$2,500 / $5,000	$3,000 / $6,000	$2,000 / $6,000	$4,000 / $8,000
Includes DED, Coins & Copays; excludes Rx	Out-of-Network	$5,000 / $10,000	$5,000 / $10,000	$6,000 / $12,000	$6,000 / $12,000	$8,000 / $16,000
Prescription Drug Program		**See Pharmacy Options**				

Benefit Maximums[3]

Lifetime Maximum	$5,000,000
Adult Wellness - In Network	No Maximum
Adult Wellness - Out of Network	$150
Mental Health (Inpatient / Outpatient)	30 Days / 20 Visits
Substance Dependency (Lifetime Maximum)	$2,500
Home Health Care	$2,500
Skilled Nursing Facility	60 Days
Outpatient Therapy & Spinal Manipulations	$2,500
Ambulance (Ground/ Air & Water per day max) (DED + In-Network Coinsurance)	$5,000 combined Ground & Air/Water
Hospice (Lifetime Maximum)	No Maximum

Prescription Drug Coverage

	High	Low
In-Network		
*Pharmacy Deductible	$0	$0
Generic/Brand/Non-preferred	$10/$30/$50	$10/$60/$100
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	$25/$75/$125	$25/$150/$250
Out-of-Network		
*Pharmacy Deductible	$0	$0
Generic/Brand/Non-preferred	50% Coinsurance	50% Coinsurance
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	50% Coinsurance	50% Coinsurance

* Rx Deductible is combined IN and OON and applies to Mail Order.

[1] DED = Deductible

[2] In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] Per Benefit Period (PBP) Unless Otherwise Noted

This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc., an independent licensee of the Blue Cross and Blue Shield Association. This matrix does not constitute a Contract.

Small Group - BlueOptions Enhanced Consumer Choice Plans

Cost Sharing		5466 Predictable Cost	5467 Predictable Cost	5468 Predictable Cost	5469 Predictable Cost
Physician Office Services	In-Network Family Physician	$30 Copayment	$20 Copayment	$25 Copayment	$30 Copayment
	In-Network Specialist	$60 Copayment	$50 Copayment	$55 Copayment	$65 Copayment
	In-Network e-Office Visit	$10 Copayment	$10 Copayment	$10 Copayment	$10 Copayment
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copayment	$300 Copayment	$250 Copayment	$300 Copayment
	Out-of-Network Provider	DED[1] + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Medical Pharmacy (Applies to Office Setting & Specialty Pharmacy Vendors)	In-Network Monthly Out-of-Pocket Maximum[2]	$200	$200	$200	$200
	In-Network Provider	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
	Out-of Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Emergency Room Facility Services (per visit; copayment waived if admitted)	In-Network	$250 Copayment	$200 Copayment	$200 Copayment	$250 Copayment
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Independent Diagnostic Testing Facility Services (Fac./Phy. Charges billes as one bill)	In-Network	$50 Copayment	$50 Copayment	$50 Copayment	$50 Copayment
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copayment	$300 Copayment	$250 Copayment	$300 Copayment
	Out-of-Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Independent Clinical Lab	In-Network	$0	$0	$0	$0
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Provider Services at Hospital and ER	In-Network and Out-of-Network	In-Network DED + 20% Coinsurance	In-Network DED + 20% Coinsurance	In-Network DED + 30% Coinsurance	In-Network DED + 30% Coinsurance
Physician Services at Locations other than Office, Hosptial, and Emergency Room	In-Network Family Physician	DED + 20% Coinsurance	DED + 20% Coinsurance	$25 Copayment	$30 Copayment
	In-Network Specialist	DED + 20% Coinsurance	DED + 20% Coinsurance	$55 Copayment	$65 Copayment
	Out-of-Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Ambulatory Surgical Center Facility	In-Network	$300 Copayment	DED + 20% Coinsurance	$300 Copayment	$400 Copayment
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Inpatient Hospital Facility Services (per admission)	In-Network				
	Option 1	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Option 2	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Outpatient Hospital Facility Services (per visit)	In-Network - Therapy Services				
	Option 1	$65 Copayment	$55 Copayment	$60 Copayment	$70 Copayment
	Option 2	$75 Copayment	$65 Copayment	$70 Copayment	$80 Copayment
	In-Network - All Other Services				
	Option 1	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Option 2	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Deductible[3] (per Person / Family Aggregate)	In-Network	$2,000 / $4,000	$1,500 / $3,000	$2,000 / $4,000	$3,000 / $6,000
	Out-of-Network	$4,000 / $8,000	$3,000 / $6,000	$7,000 / $9,000	$8,000 / $10,000
Coinsurance (amount member pays)	In-Network	20%	20%	30%	30%
	Out-of-Network	50%	50%	50%	50%
Out-of-Pocket Maximum[3] (per Person / Family Aggregate) Includes DED, Coins & Copays; excludes Rx	In-Network	$3,500 / $7,000	$5,000 / $10,000	$5,000 / $9,000	$7,000 / $11,000
	Out-of-Network	$5,000 / $10,000	$6,000 / $12,000	$9,000 / $17,000	$10,000 / $20,000
Prescription Drug Program		**See Pharmacy Options**			

[1] DED = Deductible

[2] In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] Per Benefit Period (PBP) Unless Otherwise Noted

Benefit Maximums[3]

Benefit	Maximum
Lifetime Maximum	$5,000,000
Adult Wellness - In Network	No Maximum
Adult Wellness - Out of Network	$150
Mental Health (Inpatient / Outpatient)	30 Days / 20 Visits
Substance Dependency (Lifetime Maximum)	$2,500
Home Health Care	$2,500
Skilled Nursing Facility	60 Days
Outpatient Therapy & Spinal Manipulations	$2,500
Ambulance (Ground/ Air & Water per day max (DED + In-Network Coinsurance)	$5,000 combined Ground & Air/Water
Hospice (Lifetime Maximum)	No Maximum

Prescription Drug Coverage

	High	Low
In-Network		
*Pharmacy Deductible	$0	$0
Generic/Brand/Non-preferred	$10/$30/$50	$10/$60/$100
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	$25/$75/$125	$25/$150/$250
Out-of-Network		
*Pharmacy Deductible	$0	$0
Generic/Brand/Non-preferred	50% Coinsurance	50% Coinsurance
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-	50% Coinsurance	50% Coinsurance

* Rx Deductible is combined IN and OON and applies to Mail Order.

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Small Group - BlueOptions Enhanced Consumer Choice Plans

Cost Sharing		5260 Lower Cost	5261 Lower Cost	5262 Lower Cost
Physician Office Services	In-Network Family Physician	$35 Copayment	$35 Copayment	$45 Copayment
	In-Network Specialist	$100 Copayment	$100 Copayment	$100 Copayment
	In-Network e-Office Visit	$10 Copayment	$10 Copayment	$10 Copayment
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copayment	$250 Copayment	$250 Copayment
	Out-of-Network Provider	DED[1] + 40% Coinsurance	DED + 40% Coinsurance	DED + 50% Coinsurance
Medical Pharmacy (Applies to Office Setting & Specialty Pharmacy Vendors)	In-Network Monthly Out-of-Pocket Maximum[2]	$200	$200	$200
	In-Network Provider	20% Coinsurance	20% Coinsurance	20% Coinsurance
	Out-of Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Emergency Room Facility Services (per visit; copayment waived if admitted)	In-Network	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance	DED + 50% Coinsurance
Independent Diagnostic Testing Facility Services (Fac./Phy. Charges billes as one bill)	In-Network	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copayment	$250 Copayment	$250 Copayment
	Out-of-Network Provider	DED + 40% Coinsurance	DED + 40% Coinsurance	DED + 50% Coinsurance
Independent Clinical Lab	In-Network	$0	$0	$0
	Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance	DED + 50% Coinsurance
Provider Services at Hospital and ER	In-Network and Out-of-Network	In-Network DED + 20% Coinsurance	In-Network DED + 20% Coinsurance	In-Network DED + 30% Coinsurance
Physician Services at Locations other than Office, Hosptial, and Emergency Room	In-Network Family Physician	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	In-Network Specialist	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	Out-of-Network Provider	DED + 40% Coinsurance	DED + 40% Coinsurance	DED + 50% Coinsurance
Ambulatory Surgical Center Facility	In-Network	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance	DED + 50% Coinsurance
Inpatient Hospital Facility Services (per admission)	In-Network			
	Option 1	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	Option 2	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance	DED + 50% Coinsurance
Outpatient Hospital Facility Services (per visit)	In-Network - Therapy Services			
	Option 1	$105 Copayment	$105 Copayment	$105 Copayment
	Option 2	$115 Copayment	$115 Copayment	$115 Copayment
	In-Network - All Other Services			
	Option 1	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	Option 2	DED + 20% Coinsurance	DED + 20% Coinsurance	DED + 30% Coinsurance
	Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance	DED + 50% Coinsurance
Deductible[3] (per Person / Family Aggregate)	In-Network	$1,500 / $4,500	$3,000 / $9,000	$5,000 / $15,000
	Out-of-Network	$3,000 / $6,000	$6,000 / $18,000	$10,000 / $20,000
Coinsurance (amount member pays)	In-Network	20%	20%	30%
	Out-of-Network	40%	40%	50%
Out-of-Pocket Maximum[3] (per Person / Family Aggregate) Includes DED, Coins & Copays; excludes Rx	In-Network	$4,000 / $8,000	$5,500 / $11,000	$7,500 / $15,000
	Out-of-Network	$5,000 / $10,000	$8,000 / $20,000	$12,000 / $22,000
Prescription Drug Program		**See Pharmacy Options**		

[1] DED = Deductible

[2] In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] Per Benefit Period (PBP) Unless Otherwise Noted

Benefit Maximums[3]

Lifetime Maximum	$5,000,000
Adult Wellness - In Network	No Maximum
Adult Wellness - Out of Network	$150
Mental Health (Inpatient / Outpatient)	30 Days / 20 Visits
Substance Dependency (Lifetime Maximum)	$2,500
Home Health Care	$2,500
Skilled Nursing Facility	60 Days
Outpatient Therapy & Spinal Manipulations	$2,500
Ambulance (Ground/ Air & Water per day max) (DED + In-Network Coinsurance)	$5,000 combined Ground & Air/Water
Hospice (Lifetime Maximum)	No Maximum

Prescription Drug Coverage

	High	Low
In-Network		
*Pharmacy Deductible	$300 Brand Deductible	$300 Brand Deductible
Generic/Brand/Non-preferred	$10/$30/$50	$10/$60/$100
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	$25/$75/$125	$25/$150/$250
Out-of-Network		
*Pharmacy Deductible	$300 Brand Deductible	$300 Brand Deductible
Generic/Brand/Non-preferred	50% Coinsurance	50% Coinsurance
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	50% Coinsurance	50% Coinsurance

* Rx Deductible is combined IN and OON and applies to Mail Order.

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Small Group - BlueOptions Enhanced Consumer Choice Plans

Cost Sharing		5800 Lower Cost	5801 Lower Cost	5802 Lower Cost	5803 Lower Cost
Physician Office Services	In-Network Family Physician	$35 Copayment	$35 Copayment	$45 Copayment	$45 Copayment
	In-Network Specialist	$50 Copayment	$75 Copayment	DED + 50% Coinsurance	DED + 50% Coinsurance
	In-Network e-Office Visit	$10 Copayment	$10 Copayment	$10 Copayment	$10 Copayment
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copayment	$250 Copayment	$250 Copayment	$250 Copayment
	Out-of-Network Provider	DED[1] + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Medical Pharmacy (Applies to Office Setting & Specialty Pharmacy Vendors)	In-Network Monthly Out-of-Pocket Maximum[2]	$200	$200	$200	$200
	In-Network Provider	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
	Out-of Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Emergency Room Facility Services (per visit; copayment waived if admitted)	In-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Independent Diagnostic Testing Facility Services (Fac./Phy. Charges billes as one bill)	In-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copayment	$250 Copayment	$250 Copayment	$250 Copayment
	Out-of-Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Independent Clinical Lab	In-Network	$0	$0	$0	$0
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Provider Services at Hospital and ER	In-Network and Out-of-Network	In-Network DED + 50% Coinsurance	In-Network DED + 50% Coinsurance	In-Network DED + 50% Coinsurance	In-Network DED + 50% Coinsurance
Physician Services at Locations other than Office, Hosptial, and Emergency Room	In-Network Family Physician	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
	In-Network Specialist	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
	Out-of-Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Ambulatory Surgical Center Facility	In-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Inpatient Hospital Facility Services (per admission)	In-Network				
	Option 1	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
	Option 2	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Outpatient Hospital Facility Services (per visit)	In-Network - Therapy Services				
	Option 1	$55 Copayment	$80 Copayment	$80 Copayment	$80 Copayment
	Option 2	$65 Copayment	$90 Copayment	$90 Copayment	$90 Copayment
	In-Network - All Other Services				
	Option 1	$300 Copayment	$300 Copayment	$400 Copayment	$400 Copayment
	Option 2	$400 Copayment	$400 Copayment	$500 Copayment	$500 Copayment
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Deductible[3] (per Person / Family Aggregate)	In-Network	$1,500 / Not Applicable	$2,000 / Not Applicable	$1,500 / Not Applicable	$2,000 / Not Applicable
	Out-of-Network	$4,500 / Not Applicable	$6,000 / Not Applicable	$4,500 / Not Applicable	$6,000 / Not Applicable
Coinsurance (amount member pays)	In-Network	50%	50%	50%	50%
	Out-of-Network	50%	50%	50%	50%
Out-of-Pocket Maximum[3] (per Person / Family Aggregate) Includes DED, Coins & Copays; excludes Rx	In-Network	$10,000 / $10,000	$15,000 / $15,000	$10,000 / $10,000	$15,000 / $15,000
	Out-of-Network	$20,000 / $20,000	$30,000 / $30,000	$20,000 / $20,000	$30,000 / $30,000
Prescription Drug Program		**See Pharmacy Options**			

[1] DED = Deductible

[2] In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] Per Benefit Period (PBP) Unless Otherwise Noted

Benefit Maximums[3]

Lifetime Maximum	$1,000,000
Adult Wellness - In Network	No Maximum
Adult Wellness - Out of Network	$150
Mental Health (Inpatient / Outpatient)	30 Days / 20 Visits
Substance Dependency (Lifetime Maximum)	$2,500
Home Health Care	$1,000
Skilled Nursing Facility	60 Days
Outpatient Therapy & Spinal Manipulations	$1,500
Ambulance (Ground/ Air & Water per day max) (DED + In-Network Coinsurance)	$5,000 combined Ground & Air/Water
Hospice (Lifetime Maximum)	No Maximum

Prescription Drug Coverage

	High	Low
In-Network		
*Pharmacy Deductible	$800 Brand Deductible	$0
Generic/Brand/Non-preferred	$10/$60/$100	$10 Generic Only
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	$25/$150/$250	$25 Generic Only
Out-of-Network		
*Pharmacy Deductible	$800 Brand Deductible	$0
Generic/Brand/Non-preferred	50% Coinsurance	50% Coinsurance - Generic Only
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	50% Coinsurance	50% Coinsurance - Generic Only

* Rx Deductible is combined IN and OON and applies to Mail Order.

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Small Group - BlueOptions Enhanced Consumer Choice Plans

Cost Sharing		6000 Lower Cost Plan	6001 Lower Cost Plan
Physician Office Services - Surgical Services Only	In-Network Family Physician In-Network Specialist In-Network e-Office Visit In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) Out-of-Network Provider	DED[1] + 20% Coinsurance DED + 20% Coinsurance $10 Copayment DED + 20% Coinsurance DED + 40% Coinsurance	DED + 20% Coinsurance DED + 20% Coinsurance $10 Copayment DED + 20% Coinsurance DED + 40% Coinsurance
Medical Pharmacy - Applies if related to surgery (Applies to Office Setting & Specialty Pharmacy Vendors)	In-Network Monthly Out-of-Pocket Maximum[2] In-Network Provider Out-of Network Provider	$200 20% Coinsurance DED + 50% Coinsurance	$200 20% Coinsurance DED + 50% Coinsurance
Emergency Room Facility Services - Applies if admitted or related to surgery (per visit; copayment waived if admitted)	In-Network Out-of-Network	DED + 20% Coinsurance DED + 40% Coinsurance	DED + 20% Coinsurance DED + 40% Coinsurance
Emergency Room Facility Services - if Not Admitted or if no surgical services are performed	In-Network Out-of-Network	$2,500 Per Visit Deductible + 20% Coinsurance $2,500 Per Visit Deductible + 40% Coinsurance	$2,500 Per Visit Deductible + 20% Coinsurance $2,500 Per Visit Deductible + 40% Coinsurance
Independent Diagnostic Testing Facility Services - Services Related to Surgery (Fac./Phy. Charges billes as one bill)	In-Network In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) Out-of-Network Provider	DED + 20% Coinsurance DED + 20% Coinsurance DED + 40% Coinsurance	DED + 20% Coinsurance DED + 20% Coinsurance DED + 40% Coinsurance
Independent Clinical Lab - Related to Surgery Only	In-Network Out-of-Network	DED + 20% Coinsurance DED + 40% Coinsurance	DED + 20% Coinsurance DED + 40% Coinsurance
Provider Services at Hospital and ER - If admitted or if a Surgical Service is performed	In-Network and Out-of-Network	In-Network DED + 20% Coinsurance	In-Network DED + 20% Coinsurance
Physician Services at Locations other than Office, Hospital, and Emergency Room Surgical Services Only	In-Network Family Physician In-Network Specialist Out-of-Network Provider	DED + 20% Coinsurance DED + 20% Coinsurance DED + 40% Coinsurance	DED + 20% Coinsurance DED + 20% Coinsurance DED + 40% Coinsurance
Ambulatory Surgical Center Facility - Surgical Services Only	In-Network Out-of-Network	DED + 20% Coinsurance DED + 40% Coinsurance	DED + 20% Coinsurance DED + 40% Coinsurance
Inpatient Hospital Facility Services (per admission)	In-Network Option 1 Option 2 Out-of-Network	 DED + 20% Coinsurance DED + 20% Coinsurance $500 PAD + DED + 40% Coinsurance	 DED + 20% Coinsurance DED + 20% Coinsurance $500 PAD + DED + 40% Coinsurance
Outpatient Hospital Facility Services - Services Related to Surgery Only (per visit)	In-Network - Therapy Services In-Network - All Other Services Option 1 Option 2 Out-of-Network	Not Covered DED + 20% Coinsurance DED + 20% Coinsurance DED + 40% Coinsurance	Not Covered DED + 20% Coinsurance DED + 20% Coinsurance DED + 40% Coinsurance
Deductible[3] (per Person / Family Aggregate)	In-Network Out-of-Network	$250 / Not Applicable $750 / Not Applicable	$1,000 / Not Applicable $1,500 / Not Applicable
Coinsurance (amount member pays)	In-Network Out-of-Network	20% 40%	20% 40%
Out-of-Pocket Maximum[3] (per Person / Family Aggregate) Includes Hospital/Surgical DED, Coins & Copays; excludes Rx	In-Network Out-of-Network	$3,500 / Not Applicable $7,000 / Not Applicable	$5,000 / Not Applicable $10,000 / Not Applicable
Prescription Drug Program		**See Pharmacy Options**	

[1] DED = Deductible

[2] In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] Per Benefit Period (PBP) Unless Otherwise Noted

Comments

- Physician Services are covered for Inpatient Hospitalization and for Outpatient Surgeries and proximately related services only.
- Diagnostic Services are covered if proximately related to a covered surgery.
- Well Child Visits are covered.
- ER Non-Surgical Per Visit Deductible does not apply to the DED or the OOP Maximum.
- Maternity is covered.

Services not covered under these plans

- Outpatient Therapy and Spinal Manipulations
- Routine Office Visits (Preventative Adult Wellness Services and 'sick' visits for adults and children are not covered)

Benefit Maximums

Lifetime Maximum	$5,000,000
Adult Wellness - In Network	Not Covered
Adult Wellness - Out of Network	Not Covered
Mental Health (Inpatient / Outpatient)	30 Days / 20 Visits
Substance Dependency (Lifetime Maximum)	$2,500
Home Health Care	45 Visits
Skilled Nursing Facility	45 Days
Outpatient Therapy & Spinal Manipulations	Not Covered
Ambulance (Ground/ Air & Water per day max) (DED + In-Network Coinsurance)	$5,000 combined Ground & Air/Water
Hospice (Lifetime Maximum)	No Maximum

Prescription Drug Coverage

	BlueRx Discounts Program
In-Network	
*Pharmacy Deductible Generic/Brand/Non-preferred	Mail Order discounts available
Self-Admin. Injectables OOP Max	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	Mail Order discounts available
Out-of-Network	
*Pharmacy Deductible Generic/Brand/Non-preferred	Mail Order discounts available
Self-Admin. Injectables OOP Max	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	Mail Order discounts available

* Rx Deductible is combined IN and OON and applies to Mail Order.

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Small Group - BlueOptions Enhanced Consumer Choice Plans

Cost Sharing		5068	5069	5070	5071	5072	5073
		Individual	Family	Individual	Family	Individual	Family
		HSA-Compatible Plans		HSA-Compatible Plans		HSA-Compatible Plans	
Physician Office Services	In-Network Family Physician	DED[1]		DED		DED	
	In-Network Specialist	DED		DED		DED	
	In-Network e-Office Visit	DED		DED		DED	
	In-Network Advanced Imaging Services (AIS)	DED		DED		DED	
	(MRI, MRA, PET, CT & Nuclear Medicine)						
	Out-of-Network Provider	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
Medical Pharmacy	In-Network Monthly Out-of-Pocket Maximum	No Maximum		No Maximum		No Maximum	
(Applies to Office Setting & Specialty Pharmacy Vendors)	In-Network Provider	DED		DED		DED	
	Out-of Network Provider	DED + 50% Coinsurance		DED + 50% Coinsurance		DED + 50% Coinsurance	
Emergency Room Facility Services	In-Network	DED		DED		DED	
(per visit; copayment waived if admitted)	Out-of-Network	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
Independent Diagnostic Testing Facility Services							
(Fac./Phy. Charges billes as one bill)							
	In-Network	DED		DED		DED	
	In-Network Advanced Imaging Services (AIS)	DED		DED		DED	
	(MRI, MRA, PET, CT & Nuclear Medicine)						
	Out-of-Network Provider	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
Independent Clinical Lab	In-Network	DED		DED		DED	
	Out-of-Network	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
Provider Services at Hospital and ER	In-Network and Out-of-Network	In-Network DED		In-Network DED		In-Network DED	
Physician Services at Locations other than	In-Network Family Physician	DED		DED		DED	
Office, Hospital, and Emergency Room	In-Network Specialist	DED		DED		DED	
	Out-of-Network Provider	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
Ambulatory Surgical Center Facility	In-Network	DED		DED		DED	
	Out-of-Network	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
Inpatient Hospital Facility Services	In-Network						
(per admission)	Option 1	DED		DED		DED	
	Option 2	DED		DED		DED	
	Out-of-Network	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
Outpatient Hospital Facility Services	In-Network - Therapy Services						
(per visit)	Option 1	DED		DED		DED	
	Option 2	DED		DED		DED	
	In-Network - All Other Services						
	Option 1	DED		DED		DED	
	Option 2	DED		DED		DED	
	Out-of-Network	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
Deductible[2] (per Person / Family Aggregate)	In-Network	$2,500 / Not Applicable	$5,000 / $5,000	$3,500 / Not Applicable	$7,000 / $7,000	$5,000 / Not Applicable	$10,000 / $10,000
	Out-of-Network	$5,000 / Not Applicable	$10,000 / $10,000	$7,000 / Not Applicable	$14,000 / $14,000	$10,000 / Not Applicable	$20,000 / $20,000
Coinsurance (amount member pays)	In-Network	0%		0%		0%	
	Out-of-Network	20%		20%		20%	
Out-of-Pocket Maximum[2] (per Person / Family Aggregate)	In-Network	$2,500 / Not Applicable	$5,000 / $5,000	$3,500 / Not Applicable	$7,000 / $7,000	$5,000 / Not Applicable	$10,000 / $10,000
Includes DED, Coins & Copays; excludes Rx	Out-of-Network	$10,000 / Not Applicable	$20,000 / $20,000	$14,000 / Not Applicable	$28,000 / $28,000	$10,000 / Not Applicable	$20,000 / $20,000
Prescription Drug Program		**See Pharmacy Options**					

[1] DED = Deductible

[2] Per Benefit Period (PBP) Unless Otherwise Noted

Comments

- Separate plans for individual and family coverage
- Family Purchaser plans – each individual's amount within a family accumulates toward the DED.
  IN & OON DEDs do not cross accumulate. Member pays allowed amount up to DED.
- In-Network Independent Clinical Lab services are paid at 100% after DED has been met.
- Preventive Adult Wellness Services are not subject to DED.

Benefit Maximums[3]

Lifetime Maximum	$5,000,000
Adult Wellness - In Network	No Maximum
Adult Wellness - Out of Network	$150
Mental Health (Inpatient / Outpatient)	30 Days / 20 Visits
Substance Dependency (Lifetime Maximum)	$2,500
Home Health Care	$2,500
Skilled Nursing Facility	60 Days
Outpatient Therapy & Spinal Manipulations	$2,500
Ambulance (Ground/ Air & Water per day max) (DED + In-Network Coinsurance)	$5,000 combined Ground & Air/Water
Hospice (Lifetime Maximum)	No Maximum

Prescription Drug Coverage

	High	Low
In-Network		
Pharmacy Deductible	In-network health plan deductible	BlueRx Discounts Mail Order available
Generic/Brand/Non-preferred	100% after In-network health plan deductible	
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	100% after In-network health plan deductible	BlueRx Discounts Mail Order available
Out-of-Network		
*Pharmacy Deductible	In-network health plan deductible	BlueRx Discounts Mail Order available
Generic/Brand/Non-preferred	50% Coinsurance after In-network health plan deductible	
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	50% Coinsurance after In-network health plan deductible	BlueRx Discounts Mail Order available

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Small Group - BlueOptions Enhanced Consumer Choice Plans

Cost Sharing		5040	5041	5042	5043	5020	5021	5022	5023
		Individual	Family	Individual	Family	Individual	Family	Individual	Family
		HSA-Compatible Plans		HSA-Compatible Plans		HSA-Compatible Plans		HSA-Compatible Plans	
Physician Office Services	In-Network Family Physician	DED[1] + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	In-Network Specialist	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	In-Network e-Office Visit	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Out-of-Network Provider	DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance	
Medical Pharmacy	In-Network Monthly Out-of-Pocket Maximum[2]	$200		$200		$200		$200	
(Applies to Office Setting & Specialty Pharmacy Vendors)	In-Network Provider	DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Out-of Network Provider	DED + 50% Coinsurance		DED + 50% Coinsurance		DED + 50% Coinsurance		DED + 50% Coinsurance	
Emergency Room Facility Services	In-Network	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
(per visit; copayment waived if admitted)	Out-of-Network	DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance	
Independent Diagnostic Testing Facility Services (Fac./Phy. Charges billes as one bill)									
	In-Network	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Out-of-Network Provider	DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance	
Independent Clinical Lab	In-Network	DED		DED		DED		DED	
	Out-of-Network	DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance	
Provider Services at Hospital and ER	In-Network and Out-of-Network	In-Network DED + 10% Coinsurance		In-Network DED + 10% Coinsurance		In-Network DED + 20% Coinsurance		In-Network DED + 20% Coinsurance	
Physician Services at Locations other than Office, Hospital, and Emergency Room	In-Network Family Physician	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	In-Network Specialist	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Out-of-Network Provider	DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance	
Ambulatory Surgical Center Facility	In-Network	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Out-of-Network	DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance	
Inpatient Hospital Facility Services	In-Network								
(per admission)	Option 1	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Option 2	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Out-of-Network	DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance	
Outpatient Hospital Facility Services	In-Network - Therapy Services								
(per visit)	Option 1	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Option 2	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	In-Network - All Other Services								
	Option 1	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Option 2	DED + 10% Coinsurance		DED + 10% Coinsurance		DED + 20% Coinsurance		DED + 20% Coinsurance	
	Out-of-Network	DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance		DED + 40% Coinsurance	
Deductible[3] (per Person / Family Aggregate)	In-Network	$1,500 / Not Applicable	$3,000 / $3,000	$2,500 / Not Applicable	$5,000 / $5,000	$1,500 / Not Applicable	$3,000 / $3,000	$2,500 / Not Applicable	$5,000 / $5,000
	Out-of-Network	$3,000 / Not Applicable	$6,000 / $6,000	$5,000 / Not Applicable	$10,000 / $10,000	$3,000 / Not Applicable	$6,000 / $6,000	$5,000 / Not Applicable	$10,000 / $10,000
Coinsurance (amount member pays)	In-Network	10%		10%		20%		20%	
	Out-of-Network	40%		40%		40%		40%	
Out-of-Pocket Maximum[3] (per Person / Family Aggregate)	In-Network	$3,000 / Not Applicable	$6,000 / $6,000	$5,000 / Not Applicable	$10,000 / $10,000	$4,500 / Not Applicable	$9,000 / $9,000	$5,800 / Not Applicable	$11,600 / $11,600
Includes DED, Coins & Copays; excludes Rx	Out-of-Network	$6,000 / Not Applicable	$12,000 / $12,000	$10,000 / Not Applicable	$20,000 / $20,000	$9,000 / Not Applicable	$18,000 / $18,000	$11,600 / Not Applicable	$23,200 / $23,200
Prescription Drug Program		**See Pharmacy Options**							

[1] DED = Deductible

[2] Monthly OOP max does not apply until the In-Network DED is met. In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] Per Benefit Period (PBP) Unless Otherwise Noted

Comments

- Separate plans for individual and family coverage
- Family Purchaser plans – each individual's amount within a family accumulates toward the DED. In & OON DEDs do not cross accumulate. Member pays allowed amount up to DED.
- In-Network Independent Clinical Lab services are paid at 100% after DED has been met.
- Preventive Adult Wellness Services are not subject to DED.

Benefit Maximums[3]

Lifetime Maximum	$5,000,000
Adult Wellness - In Network	No Maximum
Adult Wellness - Out of Network	$150
Mental Health (Inpatient / Outpatient)	30 Days / 20 Visits
Substance Dependency (Lifetime Maximum)	$2,500
Home Health Care	$2,500
Skilled Nursing Facility	60 Days
Outpatient Therapy & Spinal Manipulations	$2,500
Ambulance (Ground/ Air & Water per day max) (DED + In-Network Coinsurance)	$5,000 combined Ground & Air/Water
Hospice (Lifetime Maximum)	No Maximum

Prescription Drug Coverage

	High	Low
In-Network		
Pharmacy Deductible	In-network health plan deductible	BlueRx Discounts Mail Order available
Generic/Brand/Non-preferred	$10/$50/$80 after In-network health plan deductible	
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	$25/$125/$200	BlueRx Discounts Mail Order available
Out-of-Network		
*Pharmacy Deductible	In-network health plan deductible	BlueRx Discounts Mail Order available
Generic/Brand/Non-preferred	50% Coinsurance after In-network health plan deductible	
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	50% Coinsurance after In-network health plan deductible	BlueRx Discounts Mail Order available

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Small Group - Annual Maximum Plans

Cost Sharing		6200 MyBasic Plan	6201 MyBasic Plan	6202 MyBasic Plan	6203 MyBasic Plan
Benefit Period Maximum		$5,000	$10,000	$25,000	$50,000
Physician Office Services	In-Network Family Physician	$35 Copayment	$35 Copayment	$35 Copayment	$40 Copayment
This plan has a six (6) physician office visit maximum	In-Network Specialist	$60 Copayment	$60 Copayment	$60 Copayment	$75 Copayment
per person, per benefit period. e-Office visits	In-Network e-Office Visit	$10 Copayment	$10 Copayment	$10 Copayment	$10 Copayment
do not count towards your office visit maximum.	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copayment	$250 Copayment	$250 Copayment	$250 Copayment
	Out-of-Network Provider	DED[1] + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Medical Pharmacy	In-Network Monthly Out-of-Pocket Maximum[2]	$200	$200	$200	$200
(Applies to Office Setting & Specialty Pharmacy Vendors)	In-Network Provider	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
	Out-of Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Emergency Room Facility Services	In-Network	$150 Copayment	$150 Copayment	$150 Copayment	$150 Copayment
(per visit; copayment waived if admitted)	Out-of-Network	$300 Copayment	$300 Copayment	$300 Copayment	$300 Copayment
Independent Diagnostic Testing Facility Services (Fac./Phy. Charges billes as one bill)	In-Network	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copayment	$250 Copayment	$250 Copayment	$250 Copayment
	Out-of-Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Independent Clinical Lab	In-Network	$0	$0	$0	$0
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Provider Services at Hospital and ER	In-Network and Out-of-Network	In-Network DED + 30% Coinsurance	In-Network DED + 30% Coinsurance	In-Network DED + 30% Coinsurance	In-Network DED + 30% Coinsurance
Physician Services at Locations other than Office, Hosptial, and	In-Network Family Physician	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
Emergency Room	In-Network Specialist	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Out-of-Network Provider	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Ambulatory Surgical Center Facility	In-Network	$300 Copayment	$300 Copayment	$300 Copayment	$300 Copayment
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Inpatient Hospital Facility Services	In-Network				
(per admission)	Option 1	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Option 2	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Outpatient Hospital Facility Services	In-Network - Therapy Services				
(per visit)	Option 1	$65 Copayment	$65 Copayment	$65 Copayment	$80 Copayment
	Option 2	$75 Copayment	$75 Copayment	$75 Copayment	$90 Copayment
	In-Network - All Other Services				
	Option 1	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Option 2	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance	DED + 30% Coinsurance
	Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance	DED + 50% Coinsurance
Deductible[3] (per Person / Family Aggregate)	In-Network	$1,000 / $2,000	$1,000 / $2,000	$1,000 / $2,000	$1,000 / $2,000
	Out-of-Network	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000
Coinsurance (amount member pays)	In-Network	30%	30%	30%	30%
	Out-of-Network	50%	50%	50%	50%
Out-of-Pocket Maximum[3] (per Person / Family Aggregate)	In-Network	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Includes DED, Coins & Copays; excludes Rx	Out-of-Network	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Prescription Drug Program		**See Pharmacy Options**			

[1] DED = Deductible

[2] In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] Per Benefit Period (PBP) Unless Otherwise Noted

Benefit Maximums[3]

Benefit Period Maximum	Varies by plan
Lifetime Maximum	Unlimited
Adult Wellness - In Network	No Maximum
Adult Wellness - Out of Network	$150
Mental Health (Inpatient / Outpatient)	30 Days / 20 Visits
Substance Dependency (Lifetime Maximum)	$2,500
Home Health Care	$2,500
Skilled Nursing Facility	60 Days
Outpatient Therapy & Spinal Manipulations	$1,500
Ambulance (Ground/ Air & Water per day max) (DED + In-Network Coinsurance)	$5,000 combined Ground & Air/Water
Hospice (Lifetime Maximum)	No Maximum

Prescription Drug Coverage

	High	Low
In-Network		
*Pharmacy Deductible	$800 Brand Deductible	$0
Generic/Brand/Non-preferred	$10/$60/$100	$10/ N/A / N/A
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	$25/$150/$250	$25/ N/A / N/A
Out-of-Network		
*Pharmacy Deductible	$800 Brand Deductible	$0
Generic/Brand/Non-preferred	50% Coinsurance	50% Coins - Generic Only
Self-Admin. Injectables OOP Max	N/A	N/A
Mail Order (90 days) - Generic/Brand/Non-preferred (Deductible applies to Mail Order)	50% Coinsurance	50% Coins - Generic Only

* Rx Deductible is combined IN and OON and applies to Mail Order.

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