

Benefits Comparison

All Coinsurance Amounts Represent the Members Responsibility **After the Deductible is Met**

	PPO Blue HDHP		Advance Blue PPO		Direct Blue PPO	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
H.S.A. Comptible	Yes		No		No	
Individual Deductible	\$1,200/\$2,600/\$3,500	Choice of network deductible applies to out-of-network benefits	\$1,200/\$2,600/\$3,500 Medical Only	Choice of network deductible applies to out-of-network benefits	\$250/\$500	\$500
Family Deductible	\$2,400/\$5,200/\$7,000	Choice of network deductible applies to out-of-network benefits	\$2,400/\$5,200/\$7,000 Medical Only	Choice of network deductible applies to out-of-network benefits	\$750/\$1,500	\$500/\$1,500
Individual Out-of-Pocket Limit	\$1,000/\$1,200/\$1,500	\$2,000/\$2,400/\$3,000	\$1,000/\$1,200/\$1,500	\$2,000/\$2,400/\$3,000	\$1,500	
Family Out-of-Pocket Limit	\$2,000/\$2,400/\$3,000	\$4,000/\$4,800/\$6,000	\$2,000/\$2,400/\$3,000	\$4,000/\$4,800/\$6,000	\$4,500	
Coinsurance	90%	70%	90%	70%	90%	70%
Benefit Period and Lifetime Limits	Unlimited					
Preventive Care Adult Care Immunizations Mammogram Pediatric Care Immunizations	100% exempt from deductible	Not covered, except for Pediatric Care at 70%	100% exempt from deductible	Not covered, except for Pediatric Care at 70%	100% exempt from deductible	Not covered, except for Pediatric Care at 70%
Office Visits	90%	70%	\$20 PCP; \$30 Specialist,dedustible and coinsurance do not apply	70%	90%	70%
Emergency Care	90%		90%		90% after \$40 copayment (waived if admitted)	
Basic Diagnostic Services	90%	70%	\$20 PCP; \$30 Specialist,dedustible and coinsurance do not apply	70%	90%	70%

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Advanced Diagnostic Services Inpatient/Outpatient Services Maternity and Newborn Care Outpatient Rehabilitation and Therapy Services Spinal Manipulation	90%	70%	90%	70%	90%	70%
Perscription Drugs	You pay a prescription discounted cost and are reimbursed 90% after you meet your deductible; then 100% after you meet your out-of-pocket limit	Not covered	\$8 generic; \$40 brand name drugs, then 100% closed formulary; mandatory hard generic; deductible and coinsurance do not apply	Not covered	\$100 deductible/ per calendar year; then 100%; \$10 generic, \$20 brand; closed formulary; mandatory hard generic	Not covered
Preventive Medications	100%; exempt from deductible	Not covered	100%; exempt from deductible	Not covered	100%; exempt from deductible	Not covered
Eye Examinations and Refractions	Not covered; Effective 10/1/11, 100%; one eye exam every 24 months; exempt from deductible; services must be provided by a participating provider		100%; one eye exam every 24 months; exempt from deductible; services must be provided by a participating provider	Not covered	100%; one eye exam every 24 months; exempt from deductible; services must be provided by a participating provider	Not covered