

MEDICAL BENEFIT SUMMARIES

(Chart illustrates your cost)

	HMO BCN	CDHP with Access to an HSA BCBSM		PPO 1 BCBSM		PPO 2 BCBSM	
	In-Network ONLY	In- Network	Out- Network	In- Network	Out- Network	In- Network	Out- Network

COPAY SERVICES

PREVENTIVE SERVICES

Health Maintenance Exam	\$0	\$0	Not covered	\$0	Not covered	\$0	Not covered
Annual Gynecological Exam	\$0	\$0	Not covered	\$0	Not covered	\$0	Not covered
Well-Baby & Child Care	\$0	\$0	Not covered	\$0	Not covered	\$0	Not covered
Immunizations—pediatric and adult	\$0	\$0	Not covered	\$0	Not covered	\$0	Not covered
Prostate Specific Antigen (PSA) Screening	\$0	\$0	Not covered	\$0	Not covered	\$0	Not covered
Mammogram (one per year)	\$0	\$0	40% *	\$0	40% *	\$0	40% *

PHYSICIAN OFFICE SERVICES

Office Visits	\$30 copay	20% *	40% *	\$30 copay	40% *	\$30 copay	40% *
Specialist Visits	\$30 copay	20% *	40% *	\$30 copay	40% *	\$30 copay	40% *
Online Visits	\$10 copay	20% *	40% *	\$10 copay	Not Covered	\$10 copay	Not Covered

EMERGENCY MEDICAL CARE

Emergency Room (waived if admitted)	\$150 copay	20% *	20% *	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Urgent Care	\$30 copay	20% *	40% *	\$30 copay	40% *	\$30 copay	40% *
Ambulance	20% *	20% *	20% *	20% *	20% *	20% *	20% *

PRESCRIPTION DRUGS (APPLIES TO IN-NETWORK PHARMACIES ONLY)

Retail (Up to a 34-day supply)							
Generic	\$10			\$10		\$10	
Formulary	\$40	20% *		\$40		\$40	
Non-Formulary Brand	\$80			\$80		\$80	
Retail 90 (Up to a 90-day supply)							
Generic	\$20			\$20		\$20	
Formulary	\$80	20% *		\$80		\$80	
Non-Formulary Brand	\$160			\$160		\$160	
Mail-Order (Up to a 90-day supply)							
Generic	\$20			\$20		\$20	
Formulary	\$80	20% *		\$80		\$80	
Non-Formulary Brand	\$160			\$160		\$160	

DEDUCTIBLES COINSURANCE AND MAXIMUMS

Deductible (See page 5 for information regarding the CDHP Deductible)	\$2,250 Single \$4,500 Family	\$1,750 Single \$3,500 Family	\$3,500 Single \$7,000 Family	\$2,750 Single \$5,500 Family	\$5,500 Single \$11,000 Family	\$1,750 Single \$3,500 Family	\$3,500 Single \$7,000 Family
Coinsurance	20%	20%	40%	20%	40%	20%	40%
Coinsurance Maximum (includes coinsurance only)	\$1,500 Single \$3,000 Family	NA	NA	\$2,750 Single \$5,500 Family	\$5,500 Single \$11,000 Family	\$2,000 Single \$4,000 Family	\$4,000 Single \$8,000 Family
Annual Out-of-Pocket Maximum (includes deductible, coinsurance, and copays, including office visits and prescription drugs)	\$6,350 Single \$12,700 Family	\$3,000 Single \$6,000 Family	\$6,000 Single \$12,000 Family	\$6,350 Single \$12,700 Family	\$12,700 Single \$25,400 Family	\$6,350 Single \$12,700 Family	\$12,700 Single \$25,400 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

*Indicates the deductible applies.

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	In-Network ONLY	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
HOSPITAL CARE (Nonemergency services must be rendered in a participating hospital)							
Hospital Visits	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Hospital—Inpatient	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Surgery	20% *	20% *	40% *	20% *	40% *	20% *	40% *
MENTAL HEALTH & SUBSTANCE ABUSE EXPENSES (Must be provided by a participating hospital, inpatient facility or outpatient facility)							
Inpatient	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Outpatient	\$30 copay	20% *	20% *, 40% *	20% *	20% *, 40% *	20% *	20% *, 40% *
ALL OTHER SERVICES							
Allergy Testing / Injections	Testing and Serum 50% Injections \$5 copay	20% *	40% *	\$0	40% *	\$0	40% *
Anesthesia	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Chiropractic Care	(30 visits per year)	(24 visits per year)		(24 visits per year)		(24 visits per year)	
- Office visit	\$30 copay	20% *	40% *	\$30 copay	40% *	\$30 copay	40% *
- Spinal Manipulation	\$30 copay	20% *	40% *	\$0	40% *	\$0	40% *
- X-rays	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Contraceptive Devices, Implants, and Injections	\$0	\$0	40% *	\$0	40% *	\$0	40% *
Dialysis	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Fertility Testing	50%*	20% *	40% *	20% *	40% *	20% *	40% *
Home Health Care	\$30 copay	20% *	40% *	20% *	20% *	20% *	20% *
Hospice	\$0	20% *		\$0-			
		Limited to four 90-day periods (Respite care limited to 5 days during a 30 day period) Provided through a participating hospice program only					
Labs and X-ray Test	Labs—\$0 X-ray—20%*	20% *	40% *	20% *	40% *	20% *	40% *
Medical Equipment	50%	20% *	20% *	20% *	20% *	20% *	20% *
Medical Supplies	50%	20% *	20% *	20% *	20% *	20% *	20% *
Physical, Speech and Occupational Therapy	\$30 copay	20% *	40% *	20% *	40% *	20% *	40% *
- Maximum Visits	60 per calendar year	60 per calendar year		60 per calendar year		60 per calendar year	
Orthotics	50%	20% *	20% *	20% *	20% *	20% *	20% *
Maternity							
- Pre and Post Natal Care	\$30 copay	\$0	40% *	\$0	40% *	\$0	40% *
- Delivery	20%*	20% *	40% *	20% *	40% *	20% *	40% *
Prosthetic Devices	50%	20% *	20% *	20% *	20% *	20% *	20% *
Skilled Nursing Facility	20% *	20% *	40% *	20% *	20% *	20% *	20% *
- Maximum Visits	45 per calendar year	120 per calendar year		120 per calendar year		120 per calendar year	

*Indicates the deductible applies.