

Type of Care/Plan Benefits	BluePreferred PPO "A" - High Option		BluePPO "B" - Low Option	
	In Network	Out of Network	In Network	Out of Network
<b>Plan features</b>				
Primary Care Physician (PCP)	Not required		Not required	
Referrals	Not required		Not required	
Out of network benefits	Covered		Covered	
Out of area benefits	Coverage provided worldwide through the BlueCard program.		Coverage provided worldwide through the BlueCard program.	
Student/Dependent coverage	19/25		19/25	
Domestic Partner	Not covered		Not covered	
<b>Plan cost-sharing highlights</b>				
Office visit copay (PCP)	\$5 copay	None	\$20 copay	None
Office visit copay (Specialist)	\$5 copay	None	\$20 copay	None
Coinsurance	None	None	None	30%
Deductible	None	None	None	\$750 Individual/\$2,250 Family
Out of pocket maximum	None	None	None	\$2,000 Individual/ \$6,000 Family
Lifetime maximum	None		None	
<b>Preventive Health Care Services</b>				
Well child visits	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered in full
Adult routine physical exams	\$5 copay per visit, limited to one exam per calendar year	Not covered	\$20 copay per visit, limited to one exam per calendar year	Covered at 70%, subject to the deductible for one routine exam per calendar year
Adult immunizations	Not covered	Not covered	\$20 copay per visit	Covered at 70%, subject to the deductible
Mammography	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Pap smear	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Routine GYN exam	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Prostate cancer screening	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay	Covered at 70%, subject to the deductible
Routine vision	\$35 allowance for one routine eye exam per year. Eyewear: Frames \$50 allowance, Lenses Single Vision \$30 allowance, Bifocal \$40 allowance, Trifocal \$50 allowance, Contact Lenses \$60 allowance.	Not covered	\$20 copay for one routine eye exam every year. \$100 eyewear allowance every year.	Covered at 70%, subject to the deductible for one routine exam per calendar year. \$100 eyewear allowance available per calendar year.
Colonoscopy	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Preventive and diagnostic covered according to the surgical benefit.	Covered at 70%, subject to the deductible
<b>Physician Office Services</b>				
Diagnostic office visits	\$5 copay	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay per visit	Covered at 70%, subject to the deductible
Diagnostic x-rays	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay. Precertification applies to MRI, PET and CAT scans.	Covered at 70%, subject to the deductible. Precertification applies to MRI, PET and CAT scans.
Diagnostic laboratory and pathology	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Allergy tests	\$5 copay	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay per visit	Covered at 70%, subject to the deductible
Allergy injections	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Chemotherapy	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Radiation therapy	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
<b>Maternity Services</b>				
Prenatal and postpartum care	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay for initial visit, remainder of visits covered in full	Covered at 70%, subject to the deductible
Hospital care for mom (including delivery)	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Newborn nursery care	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
<b>Inpatient Hospital Benefits</b>				
Hospital benefits	Covered in full for unlimited days. Precertification applies.	Covered in full up to the allowed amount for unlimited days, subject to balance billing. Precertification applies.	Covered in full for unlimited days. Precertification applies.	Covered at 70%, subject to the deductible. Precertification applies.
Physician visits in the hospital	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Inpatient physical rehabilitation (60 days per year)	Not covered	Not covered	Covered in full for up to 60 days per calendar year. Precertification applies.	Covered at 70%, subject to the deductible for up to 60 days per calendar year. Precertification applies.

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Surgery	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Anesthesia	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
<b>Emergency Care</b>				
Emergency room care	\$25 copay per visit	Covered in full up to the allowed amount, subject to balance billing.	\$50 copay per visit, unless admitted within 24 hours.	\$50 copay per visit, unless admitted within 24 hours.
Freestanding urgent care center	\$25 copay per visit	Covered in full up to the allowed amount, subject to balance billing.	\$25 copay per visit	Covered at 70%, subject to the deductible
Ambulance	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay	\$20 copay
<b>Outpatient Hospital Benefits</b>				
Diagnostic x-rays	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay. Precertification applies to MRI, PET and CAT scans.	Covered at 70%, subject to the deductible. Precertification applies to MRI, PET and CAT scans.
Diagnostic laboratory and pathology	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Surgical care	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay	Covered at 70%, subject to the deductible
Chemotherapy	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
Radiation therapy	Covered in full	Covered in full up to the allowed amount, subject to balance billing.	Covered in full	Covered at 70%, subject to the deductible
<b>Mental Health and Chemical Dependence</b>				
Inpatient mental health care	Covered in full for unlimited days. Precertification applies. Effective 7/1/10.	Covered in full up to the allowed amount for unlimited days, subject to balance billing. Precertification applies. Effective 7/1/10.	Covered in full for unlimited days. Precertification applies.	Covered at 70%, subject to the deductible. Precertification applies.
Outpatient mental health care	Covered in full. Services can be provided in an outpatient facility or in a provider office. Effective 7/1/10.	Covered in full up to the allowed amount. Services can be provided in an outpatient facility or in a provider office. Effective 7/1/10.	\$20 copay. Services can be provided in an outpatient facility or in a provider office.	Covered at 70%, subject to the deductible. Services can be provided in an outpatient facility or in a provider office.
Inpatient chemical dependence	Covered in full for unlimited days. Precertification applies. Effective 7/1/10.	Covered in full up to the allowed amount for unlimited days, subject to balance billing. Precertification applies. Effective 7/1/10.	Covered in full for unlimited days. Precertification applies.	Covered at 70%, subject to the deductible. Precertification applies.
Outpatient chemical dependence	Covered in full. Effective 7/1/10.	Covered in full up to the allowed amount, subject to balance billing. Effective 7/1/10.	\$20 copay per visit	Covered at 70%, subject to the deductible
<b>Other Services</b>				
Prescription Drug	\$4 Generic/\$10 Brand, Mail Order \$0/\$5 Diabetic	Not covered	\$10/\$25/\$40, Mail Order subject to two copays per 90-day supply.	Not covered
Diabetic insulin and supplies	\$5 copay	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay for up to a 30 day supply	Covered at 70%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered in full for up to 120 days per calendar year. Precertification applies.	Covered in full up to allowed amount for up to 120 days per calendar year, subject to balance billing. Precertification applies.	Covered in full for up to 120 days per calendar year. Precertification applies.	Covered at 70%, subject to the deductible for up to 120 days per calendar year. Precertification applies.
Home care	Covered in full for 365 visits. Precertification applies.	Covered in full up to allowed amount for 365 visits, subject to balance billing. Precertification applies.	Covered in full for unlimited visits. Precertification applies.	Covered at 75%, subject to a \$50 deductible for unlimited visits per calendar year. Precertification applies.
Hospice	Covered in full for 210 days	Covered in full up to the allowed amount for 210 days, subject to balance billing.	Covered in full for unlimited days	Covered at 70%, subject to the deductible for unlimited visits per calendar year
Outpatient therapy	\$5 copay (PT, OT, ST, Cardiac Rehab, Pulmonary Therapy)	Covered in full (PT, OT, ST, Cardiac Rehab, Pulmonary Therapy) up to the allowed amount, subject to balance billing.	\$20 copay for up to a combined total of 45 visits per calendar year for physical, speech, respiratory and occupational therapy.	Covered at 70%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, occupational and respiratory therapy
Durable medical equipment	Covered in full. Precertification applies.	Covered in full up to the allowed amount, subject to balance billing. Precertification applies.	Covered at 80%. Precertification applies.	Covered at 70%, subject to the deductible. Precertification applies.
External prosthetics	Covered in full. Precertification applies.	Covered in full up to the allowed amount, subject to balance billing. Precertification applies.	Covered at 80%, up to \$15,000 per calendar year	Covered at 70%, subject to the deductible, for up to \$15,000 per calendar year
Chiropractic	\$5 copay	Covered in full up to the allowed amount, subject to balance billing.	\$20 copay per visit	Covered at 70%, subject to the deductible
Acupuncture	Not covered	Not covered	Not covered	Not covered

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Dental	Not covered	Not covered	\$20 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 70%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	Not covered	Not covered	Routine exams not covered	Routine exams not covered