	BlueOptions PPO Gold	BlueCare HMO Gold	BlueOptions HDHP Silver & HSA Individual Plan Account Funding: EE Only: $1,050	BlueOptions HDHP Silver & HSA Family Plan Account Funding: EE + 1 = $1,350 or EE + 2 = $1,650
Cost Sharing - Member's Responsibility				
Deductible (DED) (Per Person/Family Aggregate)				
In-Network	$1,200 / $2,400	$600 / $1200	$2,800 / NA	$5,600 / $5,600
Out-of-Network	$2,400 / $4,800	N/A	$5,600 / NA	$11,200 / $11,200
Coinsurance (BCBSF pays / Member pays)				
In-Network	80% / 20%	80% / 20%	80% / 20%	80% / 20%
Out-of-Network	60% / 40%	N/A	50% / 50%	50% / 50%
Out of Pocket Maximum (Per Person/Family Aggregate)				
In-Network	$6,000 / $12,000	$5,000 / $10,000	$7,000 / NA	$7,050 / $14,000
Out-of-Network	$12,000 / $24,000	N/A	$14,000 / NA	$28,000 / $28,000
Medical / Surgical Care by a Physician				
Office Services				
In-Network Family Physician	$50	$45	DED + 30%	DED + 30%
In-Network Specialist	$70	$65	DED + 30%	DED + 30%
Out-of-Network	Ded + 40%	Not Covered	DED + 50%	DED + 50%
Preventive Services (Adult & Well Child)				
Office Services				
In-Network Family Physician	$0 Copayment	$0 Copayment	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0 Copayment	$0 Copayment	$0 Copayment
Out-of-Network	40%	Not Covered	40%	40%
Medical / Surgical Care at a Facility				
Inpatient Hospital Facility (per admit)				
In-Network Option 1	$300 per day / $1,500 max	$300 per day up to $1,500 Max.	DED + 30%	DED + 30%
In-Network Option 2		Not Covered	DED + 50%	DED + 50%
Out-of-Network	Ded + 40%	Not Covered		
Outpatient Hospital Facility (per visit) (Surgical)				
In-Network	$300 copay	$300	DED + 30%	DED + 30%
Out-of-Network	Ded + 40%	Not Covered	DED + 50%	DED + 50%
Emergency and Urgent Care				
Emergency Room Facility (per visit) (No surgery performed or not admitted)				
In-Network	$250 Copayment	$250	DED + 30%	DED + 30%
Urgent Care Centers				
In-Network	$70 Copayment	$200 Copayment	DED + 30%	DED + 30%
Ambulatory Surgical Center (ASC)				
In-Network	$200 Copayment	$200 Copayment	DED + 30%	DED + 30%
Other Special Services and Locations				
TeleMedicine Services - with Teladoc				
In-Network	$0	$0	DED	DED
Prescription Drugs				
Deductible			Integrated Deductible	Integrated Deductible
In-Network - Retail				
Generic/Brand/Non-Preferred/Spec. Rx Max	$15 / $60 / $100 / $250	$15 / $45 / $65 / $250	DED + 30%	DED + 30%
In Network- Mail Order				
Generic/Brand/Non-Preferred	$40 / $150 / $250	$40 / $115 / $165	DED + 30%	DED + 30%

Note: This is a summarized version of the Summary of Benefit Coverages (SBC's). Not all benefits are illustrated above.