

		BlueOptions PPO Gold	BlueCare HMO Gold	BlueOptions HDHP Silver & HSA Individual Plan	BlueOptions HDHP Silver & HSA Family Plan
				Account Funding: EE Only: \$1,300	Account Funding: EE + 1 = \$1,600 or EE + 2 = \$1,900
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.					