

**BluePoint2 \$15**

**Healthy Blue Copay \$15/\$25**

**Healthy Blue Copay \$30/\$50**

**General Information**

**Cost Sharing Expenses**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Deductible - Single	\$0	\$300		\$0	\$500		\$0	\$500	
Deductible - Family	\$0	\$750		\$0	\$1,500		\$0	\$1,500	
Coinsurance	0%	25%		0%	20%		0%	20%	
Annual Out of Pocket Maximum - Single	\$6,350	\$6,350		\$4,200	\$4,200		\$4,200	\$4,200	
Annual Out of Pocket Maximum - Family	\$12,700	\$12,700		\$12,600	\$12,600		\$12,600	\$12,600	
Annual Out of Pocket Maximum - Per Person Cap	\$6,350	\$6,350		\$4,200	\$4,200		\$4,200	\$4,200	

**Office Visit Cost Shares**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cost Share - Primary Care	\$15 Copayment	25% Coinsurance Subject to Deductible		\$15 Copayment	20% Coinsurance Subject to Deductible		\$30 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	\$15 Copayment	25% Coinsurance Subject to Deductible		\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	\$5 PCP OV and Treatment for sick kids to age 19	25% Coinsurance Subject to Deductible		\$0 copayment for dependents to age 19 on all In-Network PCP office visits.	20% Coinsurance Subject to Deductible		\$0 copayment for dependents to age 19 on all In-Network PCP office visits.	20% Coinsurance Subject to Deductible	

**Plan Limits**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No			Yes			Yes

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**Who is Covered**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Domestic Partner Coverage			Not Covered			Not Covered			Not Covered

**Inpatient Services**

**Inpatient Facility**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Services	Covered in Full	25% Coinsurance Subject to Deductible		\$150 Copayment	20% Coinsurance Subject to Deductible		\$500 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	25% Coinsurance Subject to Deductible		\$150 Copayment	20% Coinsurance Subject to Deductible		\$500 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	25% Coinsurance Subject to Deductible		\$150 Copayment	20% Coinsurance Subject to Deductible		\$500 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	25% Coinsurance Subject to Deductible	120 Days Per Year	\$150 Copayment	20% Coinsurance Subject to Deductible	45 Days per year	\$500 Copayment	20% Coinsurance Subject to Deductible	45 Days per year
Physical Rehabilitation	Covered in Full	25% Coinsurance Subject to Deductible	60 Days per year	\$150 Copayment	20% Coinsurance Subject to Deductible	60 Days per year	\$500 Copayment	20% Coinsurance Subject to Deductible	60 Days per year
Habilitation Services	Covered in Full	25% Coinsurance Subject to Deductible	60 Days per year	\$150 Copayment	20% Coinsurance Subject to Deductible	60 Days per year	\$500 Copayment	20% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

**Inpatient Professional Services**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	Covered in Full	

**Outpatient Facility Services**

**Outpatient Facility Services**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full	25% Coinsurance Subject to Deductible		\$75 Copayment	20% Coinsurance Subject to Deductible		\$250 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	\$15 Copayment	25% Coinsurance Subject to Deductible		\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive to Primary Service	Inclusive to Primary Service		Inclusive of Primary Service	Inclusive of Primary Service		Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	\$15 Copayment	25% Coinsurance Subject to Deductible		\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Care	\$15 Copayment	25% Coinsurance Subject to Deductible		\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible	

**Home and Hospice Care**

**Home Care**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	Covered in Full	25% Coinsurance Subject to \$50 Deductible		Covered in Full	20% Coinsurance Subject to \$50 Deductible	40 Visits per year	Covered in Full	20% Coinsurance Subject to \$50 Deductible	40 Visits per year

**Hospice Care**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

**Outpatient and Office Professional Services**

**Professional Services**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		Specialist - \$25 Copayment PCP - \$15 Copayment	20% Coinsurance Subject to Deductible		Specialist - \$50 Copayment PCP - \$30 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Chiropractic Care	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		Specialist - \$25 Copayment PCP - \$15 Copayment	20% Coinsurance Subject to Deductible		Specialist - \$50 Copayment PCP - \$30 Copayment	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		Specialist - \$25 Copayment PCP - \$15 Copayment	20% Coinsurance Subject to Deductible		Specialist - \$50 Copayment PCP - \$30 Copayment	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per Year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per Year

**Rehab and Habilitation**

**Outpatient Facility**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

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## Healthy Blue Copay \$30/\$50

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Occupational Rehabilitation	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	\$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

### Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

### Preventive Services

#### Preventive Professional Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	2 Exam per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care 2nd Tier	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

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## Healthy Blue Copay \$15/\$25

## Healthy Blue Copay \$30/\$50

Benefit Name	BluePoint2 \$15			Healthy Blue Copay \$15/\$25			Healthy Blue Copay \$30/\$50		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive Facility Services Meeting Federal Guidelines\*

Benefit Name	BluePoint2 \$15			Healthy Blue Copay \$15/\$25			Healthy Blue Copay \$30/\$50		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cervical Cytology Preventative	Covered in Full	25% Coinsurance Subject to Deductible	2 per year	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	BluePoint2 \$15			Healthy Blue Copay \$15/\$25			Healthy Blue Copay \$30/\$50		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prostate Cancer Screening	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	BluePoint2 \$15			Healthy Blue Copay \$15/\$25			Healthy Blue Copay \$30/\$50		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Mammography Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

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## Healthy Blue Copay \$15/\$25

## Healthy Blue Copay \$30/\$50

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Colonoscopy Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	\$15 Copayment	25% Coinsurance Subject to Deductible		\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible	

## Other Benefits

### Additional Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Diabetic Equipment	PCP / Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	25% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - Not Covered	Not Covered		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per calendar year	PCP / Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - \$50 Copayment	20% Coinsurance Subject to Deductible	10 Visits per year
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

## Emergency Services

### ER Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Facility Emergency Room Visit	\$50 Copayment	\$50 Copayment		\$75 Copayment	\$75 Copayment		\$250 Copayment	\$250 Copayment	

### Transportation

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prehospital Emergency and Transportation - Ground or Water	\$25 Copayment	\$25 Copayment		\$75 Copayment	\$75 Copayment		\$250 Copayment	\$250 Copayment	

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**Urgent Care**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Urgent Care Center Facility Visit	\$25 Copayment	25% Coinsurance Subject to Deductible		\$25 Copayment	20% Coinsurance Subject to Deductible		\$50 Copayment	20% Coinsurance Subject to Deductible	

**Ancillary Benefits**

**Vision**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Eye Exams - Routine	\$15 Copayment	Not Covered	1 Exam every 2 calendar years	\$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year	\$50 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Eyewear - Routine	Covered	Not Covered	\$60 Reimbursement every 2 calendar years	Covered	Covered	\$60 Reimbursement Per year	Covered	Covered	\$60 Reimbursement Per year
Pediatric Eye Exams - Routine	\$15 Copayment	Not Covered	1 Exam per calendar year	\$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year	\$50 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year
Pediatric Eyewear - Routine	Covered	Not Covered	\$60 Reimbursement per calendar year	Covered	Covered	\$60 Reimbursement Per year	Covered	Covered	\$60 Reimbursement Per year

**Rx Benefits**

**Rx Plan**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Rx Plan			\$5/\$15/\$30			\$5/\$25/\$50, \$0 Gen for Kids			\$5/\$35/\$70, \$0 Gen for Kids

**Rx Benefits**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Days Supply Per Retail Order	90			30			30		
Days Supply Per Mail Order	90			90			90		
Copays Per Mail Order Supply	2			2			2		

959682 - 2 For Internal Use Only

970867 - 1 For Internal Use Only

970870 - 1 For Internal Use Only

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits. \* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.