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
DEDUCTIBLES COINSURANCE AND MAXIMUMS							
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	
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% *
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 DISORDERS & SUBSTANCE ABUSE EXPENSES (Must be provided by a participating hospital, inpatient facility or outpatient facility)							
Inpatient	20% *	20% *	Not Covered	20% *	Not Covered	20% *	Not Covered
Outpatient	$30 copay	20% *	40% *	$30 copay	40% *	$30 copay	40% *

**Indicates the deductible applies.*

MEDICAL BENEFIT SUMMARIES

(Chart illustrates your cost)	HMO BCN	CDHP with Access to an HSA		PPO Plan 1 BCBSM		PPO 2 BCBSM	
	In-Network ONLY	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
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% *	40% *	20% *	40% *
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% *	40% *	20% *	40% *	20% *	40% *
Medical Supplies	50%	20% *	40% *	20% *	40% *	20% *	40% *
Physical, Speech and Occupational Therapy *Services at nonparticipating outpatient physical therapy facilities are not covered*	$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% *	40% *	20% *	40% *	20% *	40% *
Maternity							
- Pre and Post Natal Care	$30 copay	20% *	40% *	$0	40% *	$0	40% *
- Delivery	20%*	20% *	40% *	20% *	40% *	20% *	40% *
Prosthetic Devices	50%	20% *	40% *	20% *	40% *	20% *	40% *
Skilled Nursing Facility	20% *	20% *	40% *	20% *	40% *	20% *	40% *
- Maximum Visits	45 per calendar year	120 per calendar year		120 per calendar year		120 per calendar year	
PRESCRIPTION DRUGS (APPLIES TO IN-NETWORK PHARMACIES ONLY)							
Retail (Up to a 34-day supply) Generic Formulary Non-Formulary Brand	$10 $40 $80	20% *		$10 $40 $80		$10 $40 $80	
Retail 90 (Up to a 90-day supply) Generic Formulary Non-Formulary Brand	$20 $80 $160	20% *		$20 $80 $160		$20 $80 $160	
Mail-Order (Up to a 90-day supply) Generic Formulary Non-Formulary Brand	$20 $80 $160	20% *		$20 $80 $160		$20 $80 $160	

**Indicates the deductible applies.*

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
DEDUCTIBLES COINSURANCE AND MAXIMUMS							
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	$1,250 Single $2,500 Family	$2,500 Single $5,000 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	
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% *
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 DISORDERS & SUBSTANCE ABUSE EXPENSES (Must be provided by a participating hospital, inpatient facility or outpatient facility)							
Inpatient	20% *	20% *	Not Covered	20% *	Not Covered	20% *	Not Covered
Outpatient	$30 copay	20% *	40% *	$30 copay	40% *	$30 copay	40% *

**Indicates the deductible applies.*

MEDICAL BENEFIT SUMMARIES

(Chart illustrates your cost)	HMO BCN	CDHP with Access to an HSA BCBSM		PPO Plan 1 BCBSM		PPO 2 BCBSM	
	In-Network ONLY	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
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% *	40% *	20% *	40% *
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% *	40% *	20% *	40% *
Medical Supplies	50%	20% *	40% *	20% *	40% *	20% *	40% *
Physical, Speech and Occupational Therapy *Services at nonparticipating outpatient physical therapy facilities are not covered*	$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% *	40% *	20% *	40% *	20% *	40% *
Maternity							
- Pre and Post Natal Care	$30 copay	20% *	40% *	$0	40% *	$0	40% *
- Delivery	20%*	20% *	40% *	20% *	40% *	20% *	40% *
Prosthetic Devices	50%	20% *	20% *	20% *	40% *	20% *	40% *
Skilled Nursing Facility	20% *	20% *	40% *	20% *	40% *	20% *	40% *
- Maximum Visits	45 per calendar year	120 per calendar year		120 per calendar year		120 per calendar year	
PRESCRIPTION DRUGS							
Retail (Up to a 34-day supply) Generic Formulary Non-Formulary Brand	$10 $40 $80	20% *		$10 $40 $80		$10 $40 $80	
Retail 90 (Up to a 90-day supply) Generic Formulary Non-Formulary Brand	$20 $80 $160	20% *		$20 $80 $160		$20 $80 $160	
Mail-Order (Up to a 90-day supply) Generic Formulary Non-Formulary Brand	$20 $80 $160	20% *		$20 $80 $160		$20 $80 $160	

**Indicates the deductible applies.*