

Plan Comparison Chart



	BluePPO Evolution SM	Blue PPO Options SM
Annual Deductible Options (The amount you pay each year before your plan begins to pay.)	In-Network: \$250, \$500, \$1000, \$2000, \$5000 Out-of-Network: \$500, \$1000, \$2000, \$4000, \$10,000	In-Network: There is no deductible. Out-of-Network: \$250, \$500, \$1000, \$2000
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Out-of-Pocket Limit for Coinsurance Once your annual limit is met, Blue PPO Plans pay 100% for most covered services for the remainder of the calendar year.	In-Network: Individual \$2000 Family \$5000 Out-of-Network: Individual \$4000 Family \$10,000	In-Network: Individual \$1000, \$1500, \$2000, \$2500 Each member must meet the out-of-pocket maximum. No family out-of-pocket maximum. Out-of-Network: Individual \$2000, \$2500, \$3000, \$5000 Each member must meet the out-of-pocket maximum. No family out-of-pocket maximum.
Office Services (Nonroutine Office Visits, Office Surgery, Therapeutic Injections, Allergy Care) All related services are subject to deductible/coinsurance or copayment, unless otherwise stated.	In-Network: You pay a \$20 copayment for office visit services from a PPO Primary Provider (PPP) and a \$35 copayment for a PPO Specialist Out-of-Network: Plan pays 60%, you pay 40%.	In-Network: You pay a copayment (\$10, \$15, \$20, \$30) for office visit/exam and the plan pays 100% for all other related services based on plan option (you pay 50% for allergy care). Out-of-Network: You pay coinsurance (25% or 30%) based on your plan option (some services are not covered out of network).
Adult Preventive Care Services Routine adult physicals, gynecological exams (ages 18 and older), related testing (includes routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc.).	In-Network: Plan pays 100% (no deductible) up to a \$500 maximum for each member; thereafter, services are subject to deductible and 20% coinsurance. Out-of-Network: Plan pays 60%, you pay 40%.	In-Network: You pay a copayment (\$10, \$15, \$20, \$30) for office visit/exam and Blue PPO Options pays 100% for all other related services based on plan option (you pay 50% for allergy care). Out-of-Network: No coverage.
Well Child Care Preventive Services Includes immunizations, routine testing, routine vision or hearing screenings (only through age 17).	In-Network: Plan pays 100% (no deductible) up to a \$500 maximum for each member; thereafter, services are subject to deductible and 20% coinsurance. Out-of-Network: Plan pays 60%, you pay 40%.	In-Network: You pay an office visit copayment based on your plan option, the plan pays 100%. Out-of-Network: You pay coinsurance (25% or 30%) based on your plan option (some services are not covered out of network).

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<p>Ambulance Services – Ground and Emergency Air Transport</p> <p>All services are subject to deductible/coinsurance or copayment, unless otherwise stated.</p>	<p>In-Network/Out-of-Network: Plan pays 80%, you pay 20%.</p>	<p>In-Network and Out-of-Network: You pay a \$50 ambulance copayment per trip (waived if between facilities or results in an admission).</p>
<p>Emergency Room/Emergency Observation Treatment</p> <p>All services are subject to deductible/coinsurance or copayment, unless otherwise stated.</p>	<p>In-Network: Plan pays 80% after deductible, then you pay 20%.</p> <p>Out-of-Network: Plan pays 80% after deductible, then you pay 20%.</p>	<p>In-Network and Out-of-Network: You pay an ER copayment (\$50 or \$250) based on your plan option. Plan pays 100% of ER physician charges.</p>
<p>Hospital Care and Other Services</p> <p>Includes medical/surgical inpatient services, maternity-related room and board, surgery for inpatient or outpatient, lab tests, x-ray.</p>	<p>In-Network: Plan pays 80%, you pay 20%.</p> <p>Out-of-Network: Plan pays 60%, you pay 40%.</p>	<p>In-Network: You pay an inpatient copayment based on your plan option.</p> <p>Out-of-Network: You pay coinsurance (25% or 30%) based on your plan option.</p>
<p>Maternity Services</p> <p>Includes prenatal and postnatal care, routine nursery care for covered newborns.</p>	<p>In-Network: Plan pays 80%, you pay 20% (plus a \$20 copay for a PPP or a \$35 copay for a Specialist for the first office visit).</p> <p>Out-of-Network: Plan pays 60%, you pay 40%.</p>	<p>In-Network: You pay a copayment for the initial office visit, and copayments for all other services based on place of service and type of treatment.</p> <p>Out-of-Network: You pay coinsurance (25% or 30%) based on your plan option.</p>
<p>Psychotherapeutic Services, Inpatient and Outpatient</p> <p>Includes mental health services and chemical dependency rehabilitation.</p> <p>Chemical Dependency is limited to services received within a maximum of two calendar-year benefit periods.</p>	<p>In-Network: Plan pays 80%, you pay 20%. Maximum benefit of up to \$3500 per calendar year for outpatient services and 30 days per calendar year for inpatient services.</p> <p>Out-of-Network: Plan pays 60%, you pay 40%.</p>	<p>In-Network: You pay a copayment for services based on place of service and type of treatment. Maximum benefit of up to \$3500 per calendar year for outpatient services and 30 days per calendar year for inpatient services.</p> <p>Out-of-Network: No coverage.</p>
<p>Short-Term Rehabilitation, Inpatient and Outpatient</p> <ul style="list-style-type: none"> • Services in a physical rehabilitation or skilled nursing facility • Outpatient physical, occupational, and speech therapy services 	<p>In-Network: Plan pays 80%, you pay 20%. Maximum benefit of up to \$3500 per calendar year for outpatient services and 30 days per calendar year for inpatient services.</p> <p>Out-of-Network: Plan pays 60%, you pay 40%.</p>	<p>In-Network: You pay a copayment for services based on place of service and type of treatment. Maximum benefit of up to \$3500 per calendar year for outpatient services and 30 days per calendar year for inpatient services.</p> <p>Out-of-Network: No coverage.</p>

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Prescription Drugs <ul style="list-style-type: none"> • Member savings for generic drugs • Brand-name drugs are also covered (at higher cost) • Members can save by using the prescription mail-order service 	Choice of 4-tier plans or coinsurance options.	Choice of 4-tier plans or coinsurance options.

Note: This comparison chart only provides a brief description of plan benefits for BluePPO Evolution and Blue PPO Options Plans. Please refer to the Plan Benefit Booklets and Prescription Drug Plan Riders for more complete benefit information. All services are subject to deductible/coinsurance or copayment, unless otherwise stated.