

## Individual Blue Access PPO Benefit Summary - Plan 2

Covered Benefits	Network - You Pay	Non-network -You Pay
<b>Calendar-year deductible</b>	\$250 individual/\$500 family \$500 individual/\$1,000 family \$1,000 individual/\$2,000 family \$2,500 individual/\$5,000 family	\$500 individual/\$1,000 family \$1,000 individual/\$2,000 family \$2,000 individual/\$4,000 family \$5,000 individual/\$10,000 family
<b>Out-of-pocket Limit</b> (includes deductible)	\$2,250 individual/\$4,500 family \$2,500 individual/\$5,000 family \$3,000 individual/\$6,000 family \$4,500 individual/\$9,000 family	\$4,500 individual/\$9,000 family \$5,000 individual/\$10,000 family \$6,000 individual/\$12,000 family \$9,000 individual/\$18,000 family
<b>Lifetime Maximum</b>	\$5,000,000 maximum for Network and Non-network services combined	
<b>Non-network Penalty</b>	Not applicable	50% <sup>1</sup>
<b>Prescription Drugs</b> Generic Formulary Drugs Brand-name Formulary Drugs Generic or Brand Non-formulary Drugs  Mail Service Generic Formulary Drugs Mail Service Brand-name Formulary Drugs Mail Service Generic or Brand Non-formulary Drugs	\$15 per prescription <sup>2</sup> (30-day supply, not subject to deductible) \$30 per prescription <sup>2</sup> (30-day supply, not subject to deductible) 50% with a minimum of \$45 and a maximum of \$90 per prescription <sup>2</sup> (30-day supply, not subject to deductible) \$30 per prescription <sup>2</sup> (90-day supply, not subject to deductible) \$60 per prescription <sup>2</sup> (90-day supply, not subject to deductible) \$90 per prescription <sup>2</sup> (90-day supply, not subject to deductible)	50% <sup>2</sup> (30-day supply, not subject to deductible) 50% <sup>2</sup> (30-day supply, not subject to deductible) 50% with a minimum of \$45 <sup>2</sup> , no maximum (30-day supply, not subject to deductible) Not covered Not covered Not covered
<b>Preventive Care and Well Child Care</b>	\$25 copayment for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>	50% <sup>1</sup>
<b>Physician Office Services</b>	\$25 copayment for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>	50% <sup>1</sup>
<b>Inpatient Hospital Services</b>	20% <sup>1</sup>	50% <sup>1</sup>
<b>Outpatient Services</b>	20% <sup>1</sup>	50% <sup>1</sup>
<b>Diagnostic Services</b>	20% <sup>1</sup>	50% <sup>1</sup>
<b>Emergency Room for Emergency Care</b>	20% <sup>1</sup>	20% <sup>1</sup>
<b>Urgent Care (in Urgent Care Center)</b>	\$50 copayment per visit charge <sup>2</sup> , 20% for other services <sup>1</sup>	\$50 copayment per visit charge <sup>2</sup> , 20% for other services <sup>1</sup>
<b>Mental Health Conditions</b> Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime. Inpatient mental health and substance abuse services Benefit period maximums - 10 days per benefit period (Network and Non-network combined per benefit period; \$550 combined maximum for Non-network inpatient and outpatient substance abuse) Outpatient mental health and substance abuse services Benefit period maximums - 10 visits per benefit period (Network and Non-network combined per benefit period; \$550 combined maximum for Non-network inpatient and outpatient substance abuse)	20% <sup>1</sup>  \$25 copayment for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>	50% <sup>1</sup>  50% <sup>1</sup>
<b>Outpatient Therapy Services</b>  Maximum visits per benefit period for: • Physical therapy • Speech therapy • Occupational therapy • Spinal manipulations	\$25 copayment for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>  20 visits maximum for Network and Non-network combined 20 visits maximum for Network and Non-network combined 20 visits maximum for Network and Non-network combined 12 visits maximum for Network and Non-network combined	50% <sup>1</sup>  20 visits maximum for Network and Non-network combined 20 visits maximum for Network and Non-network combined 20 visits maximum for Network and Non-network combined 12 visits maximum for Network and Non-network combined
<b>Home Health Care Services</b> Maximum visits per benefit period - 60 visits	20% <sup>1</sup>	50% <sup>1</sup>
<b>Hospice Services</b>	0% (not subject to deductible)	0% (not subject to deductible)
<b>Human Organ and Tissue Transplant Services</b> (for kidney and cornea transplants, services covered same as any other illness under Medical.) <b>Transplant Services Maximum</b> (lifetime maximum per member) \$1,000,000 lifetime combined network and non-network transplant provider services. Separate from medical lifetime of \$5,000,000. <b>Transplant, Lodging and Meals</b>	0% (network transplant facility, not subject to deductible)  0% (not subject to deductible)	50% <sup>1,2</sup> (non-network transplant facility)  50% <sup>1,2</sup>
<b>Medical Supplies, Durable Medical Equipment and Appliances</b>	50% <sup>1</sup>	50% <sup>1</sup>
<b>Optional Benefits</b>	<b>Network - You Pay</b>	<b>Non-network - You Pay</b>
<b>Optional Maternity Rider</b> Delivery charges are subject to a separate \$1,500 deductible payable after 270 days	20%	50%

<sup>1</sup> Services subject to calendar-year deductible. Network and Non-network deductibles are separate and do not accumulate towards each other.

<sup>2</sup> Copayment does not apply to deductible or out-of-pocket maximums.