

## TRADITIONAL HEALTH PLAN OPTIONS

Services	PLANS		
	<input type="checkbox"/> EnhancedBlue <sup>SM</sup> 2000 (Gold)	<input type="checkbox"/> CompleteBlue <sup>SM</sup> 4000 (Silver)	<input type="checkbox"/> SimplyBlue <sup>SM</sup> 5500 (Bronze)
Annual benefit—deductible			
Single	\$2,000	\$4,000	\$5,500
Family	\$4,000	\$8,000	\$11,000
Coinsurance—member pays	20%	30%	50%
Annual benefit—out-of-pocket maximum (OPM) in-network	Single: \$4,000 Family: \$8,000	Single: \$7,900 Family: \$15,800	Single: \$7,900 Family: \$15,800
Preventive care screenings, immunizations	Free	Free	Free
Virtual visit	\$25	\$40	\$50
Primary care office services	\$25	\$40	\$50
Non-primary care office services	\$50	\$80	Deductible / coinsurance apply
Emergency room	\$400	\$500	Deductible / coinsurance apply
Prescription drugs—Blue RX Essentials	Tier 1: \$15 Tier 2: \$50 Tier 3: \$125 Specialty preferred: \$150 Non-preferred: \$500	Tier 1: \$30 Tier 2: \$60 Tier 3: \$125 Specialty preferred: \$150 Non-preferred: \$500	For all tiers, deductible / coinsurance apply

## HIGH-DEDUCTIBLE HEALTH PLAN OPTIONS

Plan Name	PLANS		
	<input type="checkbox"/> myBlue HDHP <sup>SM</sup> Gold	<input type="checkbox"/> myBlue HDHP <sup>SM</sup> Silver	<input type="checkbox"/> myBlue HDHP <sup>SM</sup> Bronze
Annual benefit—deductible <sup>1</sup>			
Single	\$3,000	\$4,500	\$6,600
Family	\$6,000	\$9,000	\$13,200
Coinsurance—member pays	0%	0%	0%
Annual benefit—out-of-pocket maximum (OPM) in-network	Single: \$3,000 Family: \$6,000	Single: \$4,500 Family: \$9,000	Single: \$6,600 Family: \$13,200
Preventive care screenings, immunizations	Free	Free	Free
Virtual visit	Deductible applies	Deductible applies	Deductible applies
Primary care office services	Deductible applies	Deductible applies	Deductible applies
Non-primary care office services	Deductible applies	Deductible applies	Deductible applies
Emergency room	Deductible applies	Deductible applies	Deductible applies
Prescription drugs—Blue RX Essentials	Deductible applies	Deductible applies	Deductible applies

# BLUESIMPLICITY PLAN OPTIONS

Services	PLANS		
	<input type="checkbox"/> BlueSimplicity <sup>sm</sup> Gold	<input type="checkbox"/> BlueSimplicity <sup>sm</sup> Silver	<input type="checkbox"/> BlueSimplicity <sup>sm</sup> Bronze
<b>Annual benefit—out-of-pocket maximum (OPM) in-network</b> In-network	Single: \$4,000 Family: \$8,000	Single: \$7,900 Family: \$15,800	Single: \$7,900 Family: \$15,800
<b>Level 1:</b> Preventative care, Blue365 <sup>®</sup> membership, BeWell 24/7 <sup>sm</sup>	Free	Free	Free
<b>Level 2:</b> Primary care provider (PCP) office visit facility lab/X-ray , virtual visit	\$25	\$40	\$75
<b>Level 3:</b> Non-PCP office visit, outpatient PT/OT/ST, home health care, durable medical equipment	\$50	\$80	\$250
<b>Level 4:</b> Emergency room, ground ambulance, diagnostic imaging/studies and radiation therapy	\$400	\$500	\$2,000
<b>Level 5:</b> Outpatient practitioner and facility	\$2,000	\$4,000	\$5,500
<b>Level 6:</b> Hospitalization, air ambulance and skilled nursing facility	\$3,000	\$6,500	\$7,900
<b>Prescription drugs—Blue RX Essentials</b>	Level 1 medications (preventive): Free Level 2: \$20 Level 3: \$75 Level 4: \$150 Level 5: \$500	Level 1 medications (preventive): Free Level 2: \$30 Level 3: \$200 Level 4: \$300 Level 5: \$500	Level 1 medications (preventive): Free Level 2: \$75 Level 3: \$250 Level 4: \$350 Level 5: \$500

## ADD AVĒSIS VISION COVERAGE

Benefit	Benefit description
<b>Diagnostic services — \$10 copay</b> Eye exam	Covered in full after \$10 copay, every 12 months
<b>Eyewear products — \$25 materials copay</b> Frames Standard plastic lenses Contact lenses Lens options	Covered once every 24 months, after materials copay; \$80 retail allowance One pair covered in full after materials copay, every 12 months Covered up to allowance, every 12 months, in lieu of eyeglasses Up to 20 percent off polycarbonate, scratch-resistant coating, tint and UV protective coating