

Individual Blue Access PPO Benefit Summary – Plan 1

Covered Benefits	Network - You Pay	Non-network -You Pay
Calendar-year deductible	\$500 individual/\$1,000 family \$1,000 individual/\$2,000 family \$2,500 individual/\$5,000 family \$5,000 individual/\$10,000 family	\$1,000 individual/\$2,000 family \$2,000 individual/\$4,000 family \$5,000 individual/\$10,000 family \$10,000 individual/\$20,000 family
Out-of-pocket Limit (includes deductible)	\$2,500 individual/\$5,000 family \$3,000 individual/\$6,000 family \$4,500 individual/\$9,000 family \$7,000 individual/\$14,000 family	\$5,000 individual/\$10,000 family \$6,000 individual/\$12,000 family \$9,000 individual/\$18,000 family \$14,000 individual/\$28,000 family
Lifetime Maximum	\$5,000,000 maximum for Network and Non-network services combined	
Non-network Penalty	Not applicable	50% ¹
Prescription Drugs Generic Formulary Drugs Brand-name Formulary Drugs Generic Non-formulary Drugs 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 ² (30-day supply, not subject to deductible) Not covered \$15 per prescription ² (30-day supply, not subject to deductible) Brand is not covered Not covered Not covered Not covered	50% ² (30-day supply, not subject to deductible) Not covered 50% ² (30-day supply, not subject to deductible) Not covered Not covered Not covered Not covered
Preventive Care and Well Child Care	20% ¹	50% ¹
Physician Office Services	20% ¹	50% ¹
Inpatient Hospital Services	20% ¹	50% ¹
Outpatient Services	20% ¹	50% ¹
Diagnostic Services	20% ¹	50% ¹
Emergency Room for Emergency Care	20% ¹	20% ¹
Urgent Care (in Urgent Care Center)	20% ¹	20% ¹
Mental Health Conditions Benefits are provided only if authorized in advance. 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% ¹ 20% ¹	50% ¹ 50% ¹
Outpatient Therapy Services Maximum Visits per benefit period for: • Physical therapy • Speech therapy • Occupational therapy • Spinal manipulations	20% ¹ 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% ¹ 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
Home Health Care Services Maximum visits per benefit period - 60 visits	20% ¹	50% ¹
Hospice Services	0% (not subject to deductible)	0% (not subject to deductible)
Human Organ and Tissue Transplant Services (for kidney and cornea transplants, services covered same as any other illness under Medical.) Transplant Services Maximum (lifetime maximum per member) \$1,000,000 lifetime combined network and non-network transplant provider services. Separate from medical lifetime of \$5,000,000. Transportation, Lodging and Meals	0% (network transplant facility, not subject to deductible) 0% (not subject to deductible)	50% ^{1,2} (non-network transplant facility) 50% ^{1,2}
Medical Supplies, Durable Medical Equipment and Appliances	50% ¹	50% ¹
Maternity Services	Not covered	Not covered

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

² Copayment does not apply to deductible or out-of-pocket maximums.