

HB-HDHP-2		HealthyBlue HDHP	
Plan Overview			
Package ID	HB-HDHP-2		
Plan Name	HealthyBlue HDHP		
Plan Type	HDHP		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 60%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	HealthyRewards - Earn up to \$1,000. Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	No copay, office visit covered at 80% in-network and 60% out-of network, subject to the deductible		
Office visit copay (Specialist)	No copay, office visit covered at 80% in-network and 60% out-of-network, subject to the deductible		
Coinsurance	In network: Covered at 80%; Out of network: Covered at 60%		
Deductible	Combined in and out of network: \$1300 Individual / \$2600 Family		
Out of pocket maximum	Combined in and out of network: \$3000 Individual / \$6000 Family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out-of-Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 60%, subject to the deductible	
+Mammography	Covered in full	Covered at 60%, subject to the deductible	
+Pap smear	Covered in full	Covered at 60%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 60%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 60%, subject to the deductible	
Routine vision	Covered at 80%, subject to the deductible for one routine exam per year.	Covered at 60%, subject to the deductible for one routine exam per year.	
+Colonoscopy	Preventive screening covered in full	Covered at 60%, subject to the deductible	
Physician Office Services	In-Network	Out-of-Network	
Diagnostic office visits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Diagnostic x-rays	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Diagnostic laboratory and pathology	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Allergy tests	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Allergy injections	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Chemotherapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Radiation therapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Maternity Services	In-Network	Out-of-Network	
Prenatal and postpartum care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Hospital care for mom (including delivery)	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Newborn nursery care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Prescription Drug	In-Network	Out-of-Network	
Short-term and maintenance drugs	\$5/\$35/\$70; subject to plan deductible. \$0 copay for generics for children to age 19	Not covered	
Inpatient Hospital Benefits	In-Network	Out-of-Network	
Hospital benefits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Physician visits in the hospital	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Inpatient physical rehabilitation	Covered at 80%, subject to the deductible for up to 60 days per year	Covered at 60%, subject to the deductible for up to 60 days per year	

HB-HDHP-2	HealthyBlue HDHP	
Surgery	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Anesthesia	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Emergency Care	In-Network	Out-of-Network
Emergency room care	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Freestanding urgent care center	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Ambulance	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Outpatient Hospital Benefits	In-Network	Out-of-Network
Diagnostic x-rays	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Surgical care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Chemotherapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Radiation Therapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Mental Health and Chemical Dependence	In-Network	Out-of-Network
Inpatient mental health care	Covered at 80%, subject to the deductible for up to 30 days per year.	Covered at 60%, subject to the deductible for up to 30 days per year.
Outpatient mental health care	Covered at 80%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.	Covered at 60%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.
Inpatient chemical dependence	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.	Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.
Outpatient chemical dependence	Covered at 80%, subject to the deductible for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year
Other Services	In-Network	Out-of-Network
Diabetic insulin and supplies	Covered at 80%, subject to the deductible for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 80%, subject to the deductible for up to 45 days per year	Covered at 60%, subject to the deductible for up to 45 days per year
Home care	Covered at 80%, subject to the deductible for up to 40 visits per year	Covered at 60%, subject to the deductible for up to 40 visits per year
Hospice	Covered at 80%, subject to the deductible for unlimited visits per year	Covered at 60%, subject to the deductible for unlimited visits per year
Outpatient therapy	Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 60%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy
Durable medical equipment	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
External prosthetics	Covered at 80% subject to the deductible	Covered at 60%, subject to the deductible
Chiropractic	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Acupuncture	Covered at 80%, subject to the deductible, for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year
Dental	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	Covered at 80%, subject to the deductible, for one routine hearing exam per year	Covered at 60%, subject to the deductible, for one routine hearing exam per year

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. *Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

SB-HDHP-11		SimplyBlue HDHP	
Plan Overview			
Package ID	SB-HDHP-11		
Plan Name	SimplyBlue HDHP		
Plan Type	HDHP		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 60%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	No copay, office visit covered at 80% in-network and 60% out-of network, subject to the deductible		
Office visit copay (Specialist)	No copay, office visit covered at 80% in-network and 60% out-of-network, subject to the deductible		
Coinsurance	In network: Covered at 80%; Out of network: Covered at 60%		
Deductible	Combined in and out of network: \$1300 Individual / \$2600 Family		
Out of pocket maximum	Combined in and out of network: \$3000 Individual / \$6000 Family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 60%, subject to the deductible	
+Mammography	Covered in full	Covered at 60%, subject to the deductible	
+Pap smear	Covered in full	Covered at 60%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 60%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 60%, subject to the deductible	
Routine vision	Covered at 80%, subject to the deductible for one routine exam per year.	Covered at 60%, subject to the deductible for one routine exam per year.	
+Colonoscopy	Preventive screening covered in full	Covered at 60%, subject to the deductible	
Physician Office Services	In-Network	Out Of Network	
Diagnostic office visits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Diagnostic x-rays	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Diagnostic laboratory and pathology	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Allergy tests	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Allergy injections	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Chemotherapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Radiation therapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Maternity Services	In-Network	Out Of Network	
Prenatal and postpartum care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Hospital care for mom (including delivery)	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Newborn nursery care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Prescription Drug	In-Network	Out Of Network	
Short-term and maintenance drugs	\$5/\$35/\$70; subject to the plan deductible. \$0 copay for generics for children to age 19	Not covered	
Inpatient Hospital Benefits	In-Network	Out Of Network	
Hospital benefits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Physician visits in the hospital	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Inpatient physical rehabilitation	Covered at 80%, subject to the deductible for up to 60 days per year	Covered at 60%, subject to the deductible for up to 60 days per year	

SB-HDHP-11	SimplyBlue HDHP	
Surgery	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Anesthesia	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Emergency Care	In-Network	Out Of Network
Emergency room care	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Freestanding urgent care center	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Ambulance	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Outpatient Hospital Benefits	In-Network	Out Of Network
Diagnostic x-rays	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Surgical care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Chemotherapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Radiation Therapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Mental Health and Chemical Dependence	In-Network	Out Of Network
Inpatient mental health care	Covered at 80%, subject to the deductible for up to 30 days per year.	Covered at 60%, subject to the deductible for up to 30 days per year.
Outpatient mental health care	Covered at 80%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.	Covered at 60%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.
Inpatient chemical dependence	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.	Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.
Outpatient chemical dependence	Covered at 80%, subject to the deductible for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year
Other Services	In-Network	Out Of Network
Diabetic insulin and supplies	Covered at 80%, subject to the deductible for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 80%, subject to the deductible for up to 45 days per year	Covered at 60%, subject to the deductible for up to 45 days per year
Home care	Covered at 80%, subject to the deductible for up to 40 visits per year	Covered at 60%, subject to the deductible for up to 40 visits per year
Hospice	Covered at 80%, subject to the deductible for unlimited visits per year	Covered at 60%, subject to the deductible for unlimited visits per year
Outpatient therapy	Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 60%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy
Durable medical equipment	Covered at 80% subject to the deductible	Covered at 60%, subject to the deductible
External prosthetics	Covered at 80% subject to the deductible	Covered at 60%, subject to the deductible
Chiropractic	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Acupuncture	Covered at 80%, subject to the deductible, for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year
Dental	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	Covered at 80%, subject to the deductible, for one routine hearing exam per year	Covered at 60%, subject to the deductible, for one routine hearing exam per year

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. *Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

HB-HDHP-4		HealthyBlue HDHP	
Plan Overview			
Package ID	HB-HDHP-4		
Plan Name	HealthyBlue HDHP		
Plan Type	HDHP		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 100%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	HealthyRewards - Earn up to \$1,000. Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	No copay, office visit covered at 100% in-network and 100% out-of network, subject to the deductible		
Office visit copay (Specialist)	No copay, office visit covered at 100% in-network and 100% out-of-network, subject to the deductible		
Coinsurance	In network: Covered at 100%; Out of network: Covered at 100%		
Deductible	Combined in and out of network: \$2600 Individual / \$5200 Family		
Out of pocket maximum	Combined in and out of network: \$5500 Individual / \$11000 Family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out-of-Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 100%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 100%, subject to the deductible	
+Mammography	Covered in full	Covered at 100%, subject to the deductible	
+Pap smear	Covered in full	Covered at 100%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 100%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 100%, subject to the deductible	
Routine vision	Covered at 100%, subject to the deductible for one routine exam per year.	Covered at 100%, subject to the deductible for one routine exam per year.	
+Colonoscopy	Preventive screening covered in full	Covered at 100%, subject to the deductible	
Physician Office Services	In-Network	Out-of-Network	
Diagnostic office visits	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Diagnostic x-rays	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Diagnostic laboratory and pathology	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Allergy tests	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Allergy injections	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Chemotherapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Radiation therapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Maternity Services	In-Network	Out-of-Network	
Prenatal and postpartum care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Hospital care for mom (including delivery)	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Newborn nursery care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Prescription Drug	In-Network	Out-of-Network	
Short-term and maintenance drugs	\$5/\$35/\$70; subject to plan deductible. \$0 copay for generics for children to age 19	Not covered	
Inpatient Hospital Benefits	In-Network	Out-of-Network	
Hospital benefits	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Physician visits in the hospital	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Inpatient physical rehabilitation	Covered at 100%, subject to the deductible for up to 60 days per year	Covered at 100%, subject to the deductible for up to 60 days per year	

HB-HDHP-4	HealthyBlue HDHP	
Surgery	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Anesthesia	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Emergency Care	In-Network	Out-of-Network
Emergency room care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Freestanding urgent care center	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Ambulance	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Outpatient Hospital Benefits	In-Network	Out-of-Network
Diagnostic x-rays	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Surgical care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Radiation Therapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Mental Health and Chemical Dependence	In-Network	Out-of-Network
Inpatient mental health care	Covered at 100%, subject to the deductible for up to 30 days per year.	Covered at 100%, subject to the deductible for up to 30 days per year.
Outpatient mental health care	Covered at 100%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.	Covered at 100%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.
Inpatient chemical dependence	Covered at 100%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.	Covered at 100%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.
Outpatient chemical dependence	Covered at 100%, subject to the deductible for up to 60 visits per year	Covered at 100%, subject to the deductible for up to 60 visits per year
Other Services	In-Network	Out-of-Network
Diabetic insulin and supplies	Covered at 100%, subject to the deductible for up to a 30 day supply	Covered at 100%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 100%, subject to the deductible for up to 45 days per year	Covered at 100%, subject to the deductible for up to 45 days per year
Home care	Covered at 100%, subject to the deductible for up to 40 visits per year	Covered at 100%, subject to the deductible for up to 40 visits per year
Hospice	Covered at 100%, subject to the deductible for unlimited visits per year	Covered at 100%, subject to the deductible for unlimited visits per year
Outpatient therapy	Covered at 100%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 100%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy
Durable medical equipment	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
External prosthetics	Covered at 100% subject to the deductible	Covered at 100%, subject to the deductible
Chiropractic	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Acupuncture	Covered at 100%, subject to the deductible, for up to 10 visits per year	Covered at 100%, subject to the deductible, for up to 10 visits per year
Dental	Covered at 100%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 100%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	Covered at 100%, subject to the deductible, for one routine hearing exam per year	Covered at 100%, subject to the deductible, for one routine hearing exam per year

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

SB-HDHP-13		SimplyBlue HDHP	
Plan Overview			
Package ID	SB-HDHP-13		
Plan Name	SimplyBlue HDHP		
Plan Type	HDHP		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 100%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	No copay, office visit covered at 100% in-network and 100% out-of network, subject to the deductible		
Office visit copay (Specialist)	No copay, office visit covered at 100% in-network and 100% out-of-network, subject to the deductible		
Coinsurance	In network: Covered at 100%; Out of network: Covered at 100%		
Deductible	Combined in and out of network: \$2600 Individual / \$5200 Family		
Out of pocket maximum	Combined in and out of network: \$5500 Individual / \$11000 Family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 100%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 100%, subject to the deductible	
+Mammography	Covered in full	Covered at 100%, subject to the deductible	
+Pap smear	Covered in full	Covered at 100%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 100%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 100%, subject to the deductible	
Routine vision	Covered at 100%, subject to the deductible for one routine exam per year.	Covered at 100%, subject to the deductible for one routine exam per year.	
+Colonoscopy	Preventive screening covered in full	Covered at 100%, subject to the deductible	
Physician Office Services	In-Network	Out Of Network	
Diagnostic office visits	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Diagnostic x-rays	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Diagnostic laboratory and pathology	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Allergy tests	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Allergy injections	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Chemotherapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Radiation therapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Maternity Services	In-Network	Out Of Network	
Prenatal and postpartum care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Hospital care for mom (including delivery)	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Newborn nursery care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Prescription Drug	In-Network	Out Of Network	
Short-term and maintenance drugs	\$5/\$35/\$70; subject to the plan deductible. \$0 copay for generics for children to age 19	Not covered	
Inpatient Hospital Benefits	In-Network	Out Of Network	
Hospital benefits	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Physician visits in the hospital	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	
Inpatient physical rehabilitation	Covered at 100%, subject to the deductible for up to 60 days per year	Covered at 100%, subject to the deductible for up to 60 days per year	

SB-HDHP-13	SimplyBlue HDHP	
Surgery	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Anesthesia	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Emergency Care	In-Network	Out Of Network
Emergency room care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Freestanding urgent care center	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Ambulance	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Outpatient Hospital Benefits	In-Network	Out Of Network
Diagnostic x-rays	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Surgical care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Radiation Therapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Mental Health and Chemical Dependence	In-Network	Out Of Network
Inpatient mental health care	Covered at 100%, subject to the deductible for up to 30 days per year.	Covered at 100%, subject to the deductible for up to 30 days per year.
Outpatient mental health care	Covered at 100%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.	Covered at 100%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.
Inpatient chemical dependence	Covered at 100%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.	Covered at 100%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.
Outpatient chemical dependence	Covered at 100%, subject to the deductible for up to 60 visits per year	Covered at 100%, subject to the deductible for up to 60 visits per year
Other Services	In-Network	Out Of Network
Diabetic insulin and supplies	Covered at 100%, subject to the deductible for up to a 30 day supply	Covered at 100%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 100%, subject to the deductible for up to 45 days per year	Covered at 100%, subject to the deductible for up to 45 days per year
Home care	Covered at 100%, subject to the deductible for up to 40 visits per year	Covered at 100%, subject to the deductible for up to 40 visits per year
Hospice	Covered at 100%, subject to the deductible for unlimited visits per year	Covered at 100%, subject to the deductible for unlimited visits per year
Outpatient therapy	Covered at 100%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 100%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy
Durable medical equipment	Covered at 100% subject to the deductible	Covered at 100%, subject to the deductible
External prosthetics	Covered at 100% subject to the deductible	Covered at 100%, subject to the deductible
Chiropractic	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Acupuncture	Covered at 100%, subject to the deductible, for up to 10 visits per year	Covered at 100%, subject to the deductible, for up to 10 visits per year
Dental	Covered at 100%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 100%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	Covered at 100%, subject to the deductible, for one routine hearing exam per year	Covered at 100%, subject to the deductible, for one routine hearing exam per year

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

HB-CD-24		HealthyBlue Copay and Deductible	
Plan Overview			
Package ID	HB-CD-24		
Plan Name	HealthyBlue Copay and Deductible		
Plan Type	PPO		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 60%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	HealthyRewards - Earn up to \$1,000. Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	Adult: \$30 copay per visit; Children to age 19: \$0 copay per visit		
Office visit copay (Specialist)	\$50 copay per visit		
Coinsurance	In network: Covered at 80%; Out of network: Covered at 60%		
Deductible	Combined in and out of network: \$500 Individual / \$1500 Family		
Out of pocket maximum	Combined in and out of network: \$1500 Individual / \$4500 Family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 60%, subject to the deductible	
+Mammography	Covered in full	Covered at 60%, subject to the deductible	
+Pap smear	Covered in full	Covered at 60%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 60%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 60%, subject to the deductible	
Routine vision	\$50 copay for one routine exam every year. \$60 eyewear allowance available per year	Covered at 60%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year	
+Colonoscopy	Preventive screening covered in full	Covered at 60%, subject to the deductible	
Physician Office Services	In-Network	Out Of Network	
Diagnostic office visits	Adult: \$30 copay per visit to your PCP; \$50 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$50 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Diagnostic x-rays	\$50 copay per visit	Covered at 60%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible	
Allergy tests	Adult: \$30 copay per visit to your PCP; \$50 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$50 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Allergy injections	Adult: \$30 copay per visit to your PCP; \$50 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$50 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Chemotherapy	\$30 copay per visit	Covered at 60%, subject to the deductible	
Radiation therapy	\$50 copay per visit	Covered at 60%, subject to the deductible	
Maternity Services	In-Network	Out Of Network	
Prenatal and postpartum care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Hospital care for mom (including delivery)	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Newborn nursery care	Covered in full	Covered at 60%, subject to the deductible	
Prescription Drug	In-Network	Out Of Network	
Short-term and maintenance drugs	\$5/\$35/\$70; \$0 copay for generics for children to age 19	Not covered	

HB-CD-24		HealthyBlue Copay and Deductible	
Inpatient Hospital Benefits	In-Network	Out Of Network	
Hospital benefits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Physician visits in the hospital	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Inpatient physical rehabilitation	Covered at 80%, subject to the deductible for up to 60 days per year	Covered at 60%, subject to the deductible for up to 60 days per year	
Surgery	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Anesthesia	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	
Emergency Care	In-Network	Out Of Network	
Emergency room care	\$250 copay per visit, unless admitted within 24 hours	\$250 copay per visit, unless admitted within 24 hours	
Freestanding urgent care center	\$50 copay per visit	Covered at 60%, subject to the deductible	
Ambulance	\$250 copay	\$250 copay	
Outpatient Hospital Benefits	In-Network	Out Of Network	
Diagnostic x-rays	\$50 copay per visit	Covered at 60%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible	
Surgical care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Chemotherapy	\$30 copay per visit	Covered at 60%, subject to the deductible	
Radiation Therapy	\$50 copay per visit	Covered at 60%, subject to the deductible	
Mental Health and Chemical Dependence	In-Network	Out Of Network	
Inpatient mental health care	Covered at 80%, subject to the deductible for up to 30 days per year	Covered at 60%, subject to the deductible for up to 30 days per year	
Outpatient mental health care	\$50 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office	Covered at 60%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office	
Inpatient chemical dependence	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	
Outpatient chemical dependence	\$50 copay per visit for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year	
Other Services	In-Network	Out Of Network	
Diabetic insulin and supplies	\$30 copay for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply	
Skilled nursing facility	Covered at 80%, subject to the deductible for up to 45 days per year	Covered at 60%, subject to the deductible for up to 45 days per year	
Home care	Covered in full for up to 40 visits per year	Covered at 75%, subject to a \$50 deductible for up to 40 visits per year	
Hospice	Covered in full for unlimited days	Covered at 60%, subject to the deductible for unlimited visits per year	
Outpatient therapy	\$50 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 60%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy	
Durable medical equipment	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	
External prosthetics	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	
Chiropractic	\$50 copay per visit	Covered at 60%, subject to the deductible	
Acupuncture	\$50 copay for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year	
Dental	\$50 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	
Hearing	\$50 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	Covered at 60%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

SB-CD-16		SimplyBlue Copay and Deductible	
Plan Overview			
Package ID	SB-CD-16		
Plan Name	SimplyBlue Copay and Deductible		
Plan Type	PPO		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 60%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	Adult: \$30 copay per visit; Children to age 19: \$0 copay per visit		
Office visit copay (Specialist)	\$50 copay per visit		
Coinsurance	In network: Covered at 80%; Out of network: Covered at 60%		
Deductible	Combined in and out of network: \$500 Individual / \$1500 Family		
Out of pocket maximum	Combined in and out of network: \$1500 Individual / \$4500 Family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 60%, subject to the deductible	
+Mammography	Covered in full	Covered at 60%, subject to the deductible	
+Pap smear	Covered in full	Covered at 60%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 60%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 60%, subject to the deductible	
Routine vision	\$50 copay for one routine exam every year. \$60 eyewear allowance available per year	Covered at 60%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year	
+Colonoscopy	Preventive screening covered in full	Covered at 60%, subject to the deductible	
Physician Office Services	In-Network	Out Of Network	
Diagnostic office visits	Adult: \$30 copay per visit to your PCP; \$50 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$50 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Diagnostic x-rays	\$50 copay per visit	Covered at 60%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible	
Allergy tests	Adult: \$30 copay per visit to your PCP; \$50 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$50 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Allergy injections	Adult: \$30 copay per visit to your PCP; \$50 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$50 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Chemotherapy	\$30 copay per visit	Covered at 60%, subject to the deductible	
Radiation therapy	\$50 copay per visit	Covered at 60%, subject to the deductible	
Maternity Services	In-Network	Out Of Network	
Prenatal and postpartum care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Hospital care for mom (including delivery)	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Newborn nursery care	Covered in full	Covered at 60%, subject to the deductible	
Prescription Drug	In-Network	Out Of Network	
Short-term and maintenance drugs	\$5/\$35/\$70; \$0 copay for generics for children to age 19	Not covered	

SB-CD-16	SimplyBlue Copay and Deductible	
Inpatient Hospital Benefits	In-Network	Out Of Network
Hospital benefits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Physician visits in the hospital	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Inpatient physical rehabilitation	Covered at 80%, subject to the deductible for up to 60 days per year	Covered at 60%, subject to the deductible for up to 60 days per year
Surgery	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Anesthesia	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Emergency Care	In-Network	Out Of Network
Emergency room care	\$250 copay per visit, unless admitted within 24 hours	\$250 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	\$50 copay per visit	Covered at 60%, subject to the deductible
Ambulance	\$250 copay	\$250 copay
Outpatient Hospital Benefits	In-Network	Out Of Network
Diagnostic x-rays	\$50 copay per visit	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible
Surgical care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Chemotherapy	\$30 copay per visit	Covered at 60%, subject to the deductible
Radiation Therapy	\$50 copay per visit	Covered at 60%, subject to the deductible
Mental Health and Chemical Dependence	In-Network	Out Of Network
Inpatient mental health care	Covered at 80%, subject to the deductible for up to 30 days per year	Covered at 60%, subject to the deductible for up to 30 days per year
Outpatient mental health care	\$50 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office	Covered at 60%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office
Inpatient chemical dependence	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime
Outpatient chemical dependence	\$50 copay per visit for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year
Other Services	In-Network	Out Of Network
Diabetic insulin and supplies	\$30 copay for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 80%, subject to the deductible for up to 45 days per year	Covered at 60%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year	Covered at 75%, subject to a \$50 deductible for up to 40 visits per year
Hospice	Covered in full for unlimited days	Covered at 60%, subject to the deductible for unlimited visits per year
Outpatient therapy	\$50 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 60%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy
Durable medical equipment	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
Chiropractic	\$50 copay per visit	Covered at 60%, subject to the deductible
Acupuncture	\$50 copay for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year
Dental	\$50 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	\$50 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	Covered at 60%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. *Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

HB-CD-54		HealthyBlue Copay and Deductible	
Plan Overview			
Package ID	HB-CD-54		
Plan Name	HealthyBlue Copay and Deductible		
Plan Type	PPO		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 60%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	HealthyRewards - Earn up to \$1,000. Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	Adult: \$25 copay per visit; Children to age 19: \$0 copay per visit		
Office visit copay (Specialist)	\$40 copay per visit		
Coinsurance	In network: Covered at 80%; Out of network: Covered at 60%		
Deductible	Combined in and out of network: \$500 Individual / \$1500 Family		
Out of pocket maximum	Combined in and out of network: \$1500 Individual / \$4500 Family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 60%, subject to the deductible	
+Mammography	Covered in full	Covered at 60%, subject to the deductible	
+Pap smear	Covered in full	Covered at 60%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 60%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 60%, subject to the deductible	
Routine vision	\$40 copay for one routine exam every year. \$60 eyewear allowance available per year	Covered at 60%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year	
+Colonoscopy	Preventive screening covered in full	Covered at 60%, subject to the deductible	
Physician Office Services	In-Network	Out Of Network	
Diagnostic office visits	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Diagnostic x-rays	\$40 copay per visit	Covered at 60%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible	
Allergy tests	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Allergy injections	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Chemotherapy	\$25 copay per visit	Covered at 60%, subject to the deductible	
Radiation therapy	\$40 copay per visit	Covered at 60%, subject to the deductible	
Maternity Services	In-Network	Out Of Network	
Prenatal and postpartum care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Hospital care for mom (including delivery)	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Newborn nursery care	Covered in full	Covered at 60%, subject to the deductible	
Prescription Drug	In-Network	Out Of Network	
Short-term and maintenance drugs	\$5/\$35/\$70; \$0 copay for generics for children to age 19	Not covered	

HB-CD-54		HealthyBlue Copay and Deductible	
Inpatient Hospital Benefits	In-Network	Out Of Network	
Hospital benefits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Physician visits in the hospital	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Inpatient physical rehabilitation	Covered at 80%, subject to the deductible for up to 60 days per year	Covered at 60%, subject to the deductible for up to 60 days per year	
Surgery	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Anesthesia	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	
Emergency Care	In-Network	Out Of Network	
Emergency room care	\$150 copay per visit, unless admitted within 24 hours	\$150 copay per visit, unless admitted within 24 hours	
Freestanding urgent care center	\$40 copay per visit	Covered at 60%, subject to the deductible	
Ambulance	\$150 copay	\$150 copay	
Outpatient Hospital Benefits	In-Network	Out Of Network	
Diagnostic x-rays	\$40 copay per visit	Covered at 60%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible	
Surgical care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Chemotherapy	\$25 copay per visit	Covered at 60%, subject to the deductible	
Radiation Therapy	\$40 copay per visit	Covered at 60%, subject to the deductible	
Mental Health and Chemical Dependence	In-Network	Out Of Network	
Inpatient mental health care	Covered at 80%, subject to the deductible for up to 30 days per year	Covered at 60%, subject to the deductible for up to 30 days per year	
Outpatient mental health care	\$40 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office	Covered at 60%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office	
Inpatient chemical dependence	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	
Outpatient chemical dependence	\$40 copay per visit for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year	
Other Services	In-Network	Out Of Network	
Diabetic insulin and supplies	\$25 copay for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply	
Skilled nursing facility	Covered at 80%, subject to the deductible for up to 45 days per year	Covered at 60%, subject to the deductible for up to 45 days per year	
Home care	Covered in full for up to 40 visits per year	Covered at 75%, subject to a \$50 deductible for up to 40 visits per year	
Hospice	Covered in full for unlimited days	Covered at 60%, subject to the deductible for unlimited visits per year	
Outpatient therapy	\$40 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 60%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy	
Durable medical equipment	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	
External prosthetics	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	
Chiropractic	\$40 copay per visit	Covered at 60%, subject to the deductible	
Acupuncture	\$40 copay for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year	
Dental	\$40 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	
Hearing	\$40 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	Covered at 60%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

SB-CD-12		SimplyBlue Copay and Deductible	
Plan Overview			
Package ID	SB-CD-12		
Plan Name	SimplyBlue Copay and Deductible		
Plan Type	PPO		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 60%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	Adult: \$25 copay per visit; Children to age 19: \$0 copay per visit		
Office visit copay (Specialist)	\$40 copay per visit		
Coinsurance	In network: Covered at 80%; Out of network: Covered at 60%		
Deductible	Combined in and out of network: \$500 Individual / \$1500 Family		
Out of pocket maximum	Combined in and out of network: \$1500 Individual / \$4500 Family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 60%, subject to the deductible	
+Mammography	Covered in full	Covered at 60%, subject to the deductible	
+Pap smear	Covered in full	Covered at 60%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 60%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 60%, subject to the deductible	
Routine vision	\$40 copay for one routine exam every year. \$60 eyewear allowance available per year	Covered at 60%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year	
+Colonoscopy	Preventive screening covered in full	Covered at 60%, subject to the deductible	
Physician Office Services	In-Network	Out Of Network	
Diagnostic office visits	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Diagnostic x-rays	\$40 copay per visit	Covered at 60%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible	
Allergy tests	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Allergy injections	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist	Covered at 60%, subject to the deductible	
Chemotherapy	\$25 copay per visit	Covered at 60%, subject to the deductible	
Radiation therapy	\$40 copay per visit	Covered at 60%, subject to the deductible	
Maternity Services	In-Network	Out Of Network	
Prenatal and postpartum care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Hospital care for mom (including delivery)	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	
Newborn nursery care	Covered in full	Covered at 60%, subject to the deductible	
Prescription Drug	In-Network	Out Of Network	
Short-term and maintenance drugs	\$5/\$35/\$70; \$0 copay for generics for children to age 19	Not covered	

SB-CD-12	SimplyBlue Copay and Deductible	
Inpatient Hospital Benefits	In-Network	Out Of Network
Hospital benefits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Physician visits in the hospital	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Inpatient physical rehabilitation	Covered at 80%, subject to the deductible for up to 60 days per year	Covered at 60%, subject to the deductible for up to 60 days per year
Surgery	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Anesthesia	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Emergency Care	In-Network	Out Of Network
Emergency room care	\$150 copay per visit, unless admitted within 24 hours	\$150 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	\$40 copay per visit	Covered at 60%, subject to the deductible
Ambulance	\$150 copay	\$150 copay
Outpatient Hospital Benefits	In-Network	Out Of Network
Diagnostic x-rays	\$40 copay per visit	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible
Surgical care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Chemotherapy	\$25 copay per visit	Covered at 60%, subject to the deductible
Radiation Therapy	\$40 copay per visit	Covered at 60%, subject to the deductible
Mental Health and Chemical Dependence	In-Network	Out Of Network
Inpatient mental health care	Covered at 80%, subject to the deductible for up to 30 days per year	Covered at 60%, subject to the deductible for up to 30 days per year
Outpatient mental health care	\$40 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office	Covered at 60%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office
Inpatient chemical dependence	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime
Outpatient chemical dependence	\$40 copay per visit for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year
Other Services	In-Network	Out Of Network
Diabetic insulin and supplies	\$25 copay for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 80%, subject to the deductible for up to 45 days per year	Covered at 60%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year	Covered at 75%, subject to a \$50 deductible for up to 40 visits per year
Hospice	Covered in full for unlimited days	Covered at 60%, subject to the deductible for unlimited visits per year
Outpatient therapy	\$40 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 60%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy
Durable medical equipment	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
Chiropractic	\$40 copay per visit	Covered at 60%, subject to the deductible
Acupuncture	\$40 copay for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year
Dental	\$40 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	\$40 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	Covered at 60%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. *Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

HB-C-44		HealthyBlue Copay	
Plan Overview			
Package ID	HB-C-44		
Plan Name	HealthyBlue Copay		
Plan Type	PPO		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 80%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	HealthyRewards - Earn up to \$1,000. Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	Adult: \$15 copay per visit; Children to age 19: \$0 copay per visit		
Office visit copay (Specialist)	\$25 copay per visit		
Coinsurance	In network: Covered at 100%; Out of network: Covered at 80%		
Deductible	In network: None; Out of network: \$500 Individual / \$1,500 Family		
Out of pocket maximum	In network: None; Out of network \$1,500 individual /\$4,500 family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 80%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 80%, subject to the deductible	
+Mammography	Covered in full	Covered at 80%, subject to the deductible	
+Pap smear	Covered in full	Covered at 80%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 80%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 80%, subject to the deductible	
Routine vision	\$25 copay for one routine exam every year. \$60 eyewear allowance available per year	Covered at 80%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year	
+Colonoscopy	Preventive screening covered in full	Covered at 80%, subject to the deductible	
Physician Office Services	In-Network	Out Of Network	
Diagnostic office visits	Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist.	Covered at 80%, subject to the deductible	
Diagnostic x-rays	\$25 copay per visit	Covered at 80%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible	
Allergy tests	Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist.	Covered at 80%, subject to the deductible	
Allergy injections	Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist.	Covered at 80%, subject to the deductible	
Chemotherapy	\$15 copay per visit	Covered at 80%, subject to the deductible	
Radiation therapy	\$25 copay per visit	Covered at 80%, subject to the deductible	
Maternity Services	In-Network	Out Of Network	
Prenatal and postpartum care	Covered in full	Covered at 80%, subject to the deductible	
Hospital care for mom (including delivery)	Covered in full	Covered at 80%, subject to the deductible	
Newborn nursery care	Covered in full	Covered at 80%, subject to the deductible	
Prescription Drug	In-Network	Out Of Network	
Short-term and maintenance drugs	\$5/\$25/\$50; \$0 copay for generics for children to age 19	Not covered	

HB-C-44		HealthyBlue Copay	
Inpatient Hospital Benefits	In-Network	Out Of Network	
Hospital benefits	Subject to \$150 copay per admission for unlimited days	Covered at 80%, subject to the deductible	
Physician visits in the hospital	Covered in full	Covered at 80%, subject to the deductible	
Inpatient physical rehabilitation	Subject to \$150 copay per admission for up to 60 days per year	Covered at 80%, subject to the deductible for up to 60 days per year.	
Surgery	Covered in full	Covered at 80%, subject to the deductible	
Anesthesia	Covered in full	Covered in full	
Emergency Care	In-Network	Out Of Network	
Emergency room care	\$75 copay per visit, unless admitted within 24 hours	\$75 copay per visit, unless admitted within 24 hours	
Freestanding urgent care center	\$25 copay per visit	Covered at 80%, subject to the deductible	
Ambulance	\$75 copay	\$75 copay	
Outpatient Hospital Benefits	In-Network	Out Of Network	
Diagnostic x-rays	\$25 copay per visit	Covered at 80%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible	
Surgical care	\$75 copay	Covered at 80%, subject to the deductible	
Chemotherapy	\$15 copay per visit	Covered at 80%, subject to the deductible	
Radiation Therapy	\$25 copay per visit	Covered at 80%, subject to the deductible	
Mental Health and Chemical Dependence	In-Network	Out Of Network	
Inpatient mental health care	Subject to \$150 copay per admission for up to 30 days per year	Covered at 80%, subject to the deductible for up to 30 days per year	
Outpatient mental health care	\$25 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office.	Covered at 80%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office	
Inpatient chemical dependence	Subject to \$150 copay per admission for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	
Outpatient chemical dependence	\$25 copay per visit for up to 60 visits per year	Covered at 80%, subject to the deductible for up to 60 visits per year	
Other Services	In-Network	Out Of Network	
Diabetic insulin and supplies	\$15 copay for up to a 30 day supply	Covered at 80%, subject to the deductible for up to a 30 day supply	
Skilled nursing facility	Subject to \$150 copay per admission for up to 45 days per year	Covered at 80%, subject to the deductible for up to 45 days per year	
Home care	Covered in full for up to 40 visits per year	Covered at 80%, subject to a \$50 deductible for up to 40 visits per year.	
Hospice	Covered in full for unlimited visits	Covered at 80%, subject to the deductible for unlimited visits per year	
Outpatient therapy	\$25 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy	
Durable medical equipment	Covered at 50%	Covered at 50%, subject to the deductible	
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible	
Chiropractic	\$25 copay per visit	Covered at 80%, subject to the deductible	
Acupuncture	\$25 copay for up to 10 visits per year	Covered at 80%, subject to the deductible, for up to 10 visits per year	
Dental	\$25 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	
Hearing	\$25 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	Covered at 80%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. *Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

SB-C-11		SimplyBlue Copay
Plan Overview		
Package ID	SB-C-11	
Plan Name	SimplyBlue Copay	
Plan Type	PPO	
Quoting Period	01/01/2012 - 03/31/2012	
Plan features		
Primary Care Physician (PCP)	Not required	
Referrals	Not required	
Out of network benefits	Covered at 80%, subject to the deductible	
Out of area benefits	Coverage provided worldwide through the BlueCard program	
Student/Dependent coverage	Qualified dependents are covered to age 26	
Domestic partner	Covered	
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings	
Plan cost-sharing highlights		
Office visit copay (Primary Care Physician)	Adult: \$15 copay per visit; Children to age 19: \$0 copay per visit	
Office visit copay (Specialist)	\$25 copay per visit	
Coinsurance	In network: Covered at 100%; Out of network: Covered at 80%	
Deductible	In network: None; Out of network: \$500 Individual / \$1,500 Family	
Out of pocket maximum	In network: None; Out of network \$1,500 individual /\$4,500 family	
Lifetime maximum	None	
Plan Benefits		
Preventive Healthcare Services	In-Network	Out Of Network
Well child visits	Covered in full	Covered in full
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 80%, subject to the deductible for one routine exam per year
+Adult immunizations	Covered in full	Covered at 80%, subject to the deductible
+Mammography	Covered in full	Covered at 80%, subject to the deductible
+Pap smear	Covered in full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered in full	Covered at 80%, subject to the deductible
Prostate cancer screening	Covered in full	Covered at 80%, subject to the deductible
Routine vision	\$25 copay for one routine exam every year. \$60 eyewear allowance available per year	Covered at 80%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year
+Colonoscopy	Preventive screening covered in full	Covered at 80%, subject to the deductible
Physician Office Services	In-Network	Out Of Network
Diagnostic office visits	Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Diagnostic x-rays	\$25 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible
Allergy tests	Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Allergy injections	Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Chemotherapy	\$15 copay per visit	Covered at 80%, subject to the deductible
Radiation therapy	\$25 copay per visit	Covered at 80%, subject to the deductible
Maternity Services	In-Network	Out Of Network
Prenatal and postpartum care	Covered in full	Covered at 80%, subject to the deductible
Hospital care for mom (including delivery)	Covered in full	Covered at 80%, subject to the deductible
Newborn nursery care	Covered in full	Covered at 80%, subject to the deductible
Prescription Drug	In-Network	Out Of Network
Short-term and maintenance drugs	\$5/\$25/\$50; \$0 copay for generics for children to age 19	Not covered

SB-C-11		SimplyBlue Copay	
Inpatient Hospital Benefits		In-Network	Out Of Network
Hospital benefits	Subject to \$150 copay per admission for unlimited days		Covered at 80%, subject to the deductible.
Physician visits in the hospital	Covered in full		Covered at 80%, subject to the deductible
Inpatient physical rehabilitation	Subject to \$150 copay per admission for up to 60 days per year		Covered at 80%, subject to the deductible for up to 60 days per year
Surgery	Covered in full		Covered at 80%, subject to the deductible
Anesthesia	Covered in full		Covered in full
Emergency Care		In-Network	Out Of Network
Emergency room care	\$75 copay per visit, unless admitted within 24 hours		\$75 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	\$25 copay per visit		Covered at 80%, subject to the deductible
Ambulance	\$75 copay		\$75 copay
Outpatient Hospital Benefits		In-Network	Out Of Network
Diagnostic x-rays	\$25 copay per visit		Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full		Covered at 80%, subject to the deductible
Surgical care	\$75 copay		Covered at 80%, subject to the deductible
Chemotherapy	\$15 copay per visit		Covered at 80%, subject to the deductible
Radiation Therapy	\$25 copay per visit		Covered at 80%, subject to the deductible
Mental Health and Chemical Dependence		In-Network	Out Of Network
Inpatient mental health care	Subject to \$150 copay per admission for up to 30 days per year		Covered at 80%, subject to the deductible for up to 30 days per year
Outpatient mental health care	\$25 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office.		Covered at 80%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office
Inpatient chemical dependence	Subject to \$150 copay per admission for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime		Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime
Outpatient chemical dependence	\$25 copay per visit for up to 60 visits per year		Covered at 80%, subject to the deductible for up to 60 visits per year
Other Services		In-Network	Out Of Network
Diabetic insulin and supplies	\$15 copay for up to a 30 day supply		Covered at 80%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Subject to \$150 copay per admission for up to 45 days per year		Covered at 80%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year		Covered at 80%, subject to a \$50 deductible for up to 40 visits per year.
Hospice	Covered in full for unlimited visits		Covered at 80%, subject to the deductible for unlimited visits per year
Outpatient therapy	\$25 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy		Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy
Durable medical equipment	Covered at 50%		Covered at 50% subject to the deductible
External prosthetics	Covered at 50%		Covered at 50% subject to the deductible
Chiropractic	\$25 copay per visit		Covered at 80%, subject to the deductible
Acupuncture	\$25 copay for up to 10 visits per year		Covered at 80%, subject to the deductible, for up to 10 visits per year
Dental	\$25 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly		Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	\$25 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years		Covered at 80%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. *Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

HB-C-28		HealthyBlue Copay	
Plan Overview			
Package ID	HB-C-28		
Plan Name	HealthyBlue Copay		
Plan Type	PPO		
Quoting Period	01/01/2012 - 03/31/2012		
Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 80%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard program		
Student/Dependent coverage	Qualified dependents are covered to age 26		
Domestic partner	Covered		
Wellness Incentives	HealthyRewards - Earn up to \$1,000. Blue365 - Exclusive access to information, discounts & savings		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	Adult: \$25 copay per visit; Children to age 19: \$0 copay per visit		
Office visit copay (Specialist)	\$40 copay per visit		
Coinsurance	In network: Covered at 100%; Out of network: Covered at 80%		
Deductible	In network: None; Out of network: \$500 Individual / \$1,500 Family		
Out of pocket maximum	In network: None; Out of network \$1,500 individual /\$4,500 family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 80%, subject to the deductible for one routine exam per year	
+Adult immunizations	Covered in full	Covered at 80%, subject to the deductible	
+Mammography	Covered in full	Covered at 80%, subject to the deductible	
+Pap smear	Covered in full	Covered at 80%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 80%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 80%, subject to the deductible	
Routine vision	\$40 copay for one routine exam every year. \$60 eyewear allowance available per year	Covered at 80%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year	
+Colonoscopy	Preventive screening covered in full	Covered at 80%, subject to the deductible	
Physician Office Services	In-Network	Out Of Network	
Diagnostic office visits	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist.	Covered at 80%, subject to the deductible	
Diagnostic x-rays	\$40 copay per visit	Covered at 80%, subject to the deductible	
Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible	
Allergy tests	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist.	Covered at 80%, subject to the deductible	
Allergy injections	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist.	Covered at 80%, subject to the deductible	
Chemotherapy	\$25 copay per visit	Covered at 80%, subject to the deductible	
Radiation therapy	\$40 copay per visit	Covered at 80%, subject to the deductible	
Maternity Services	In-Network	Out Of Network	
Prenatal and postpartum care	Covered in full	Covered at 80%, subject to the deductible	
Hospital care for mom (including delivery)	Covered in full	Covered at 80%, subject to the deductible	
Newborn nursery care	Covered in full	Covered at 80%, subject to the deductible	
Prescription Drug	In-Network	Out Of Network	
Short-term and maintenance drugs	\$5/\$35/\$70; \$0 copay for generics for children to age 19	Not covered	

HB-C-28		HealthyBlue Copay	
Inpatient Hospital Benefits		In-Network	Out Of Network
Hospital benefits	Subject to \$500 copay per admission for unlimited days		Covered at 80%, subject to the deductible
Physician visits in the hospital	Covered in full		Covered at 80%, subject to the deductible
Inpatient physical rehabilitation	Subject to \$500 copay per admission for up to 60 days per year		Covered at 80%, subject to the deductible for up to 60 days per year.
Surgery	Covered in full		Covered at 80%, subject to the deductible
Anesthesia	Covered in full		Covered in full
Emergency Care		In-Network	Out Of Network
Emergency room care	\$250 copay per visit, unless admitted within 24 hours		\$250 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	\$40 copay per visit		Covered at 80%, subject to the deductible
Ambulance	\$250 copay		\$250 copay
Outpatient Hospital Benefits		In-Network	Out Of Network
Diagnostic x-rays	\$40 copay per visit		Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full		Covered at 80%, subject to the deductible
Surgical care	\$250 copay		Covered at 80%, subject to the deductible
Chemotherapy	\$25 copay per visit		Covered at 80%, subject to the deductible
Radiation Therapy	\$40 copay per visit		Covered at 80%, subject to the deductible
Mental Health and Chemical Dependence		In-Network	Out Of Network
Inpatient mental health care	Subject to \$500 copay per admission for up to 30 days per year		Covered at 80%, subject to the deductible for up to 30 days per year
Outpatient mental health care	\$40 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office.		Covered at 80%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office
Inpatient chemical dependence	Subject to \$500 copay per admission for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime		Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime
Outpatient chemical dependence	\$40 copay per visit for up to 60 visits per year		Covered at 80%, subject to the deductible for up to 60 visits per year
Other Services		In-Network	Out Of Network
Diabetic insulin and supplies	\$25 copay for up to a 30 day supply		Covered at 80%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Subject to \$500 copay per admission for up to 45 days per year		Covered at 80%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year		Covered at 80%, subject to a \$50 deductible for up to 40 visits per year.
Hospice	Covered in full for unlimited visits		Covered at 80%, subject to the deductible for unlimited visits per year
Outpatient therapy	\$40 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy		Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy
Durable medical equipment	Covered at 50%		Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%		Covered at 50%, subject to the deductible
Chiropractic	\$40 copay per visit		Covered at 80%, subject to the deductible
Acupuncture	\$40 copay for up to 10 visits per year		Covered at 80%, subject to the deductible, for up to 10 visits per year
Dental	\$40 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly		Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	\$40 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years		Covered at 80%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. *Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

SB-C-18		SimplyBlue Copay
Plan Overview		
Package ID	SB-C-18	
Plan Name	SimplyBlue Copay	
Plan Type	PPO	
Quoting Period	01/01/2012 - 03/31/2012	
Plan features		
Primary Care Physician (PCP)	Not required	
Referrals	Not required	
Out of network benefits	Covered at 80%, subject to the deductible	
Out of area benefits	Coverage provided worldwide through the BlueCard program	
Student/Dependent coverage	Qualified dependents are covered to age 26	
Domestic partner	Covered	
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings	
Plan cost-sharing highlights		
Office visit copay (Primary Care Physician)	Adult: \$25 copay per visit; Children to age 19: \$0 copay per visit	
Office visit copay (Specialist)	\$40 copay per visit	
Coinsurance	In network: Covered at 100%; Out of network: Covered at 80%	
Deductible	In network: None; Out of network: \$500 Individual / \$1,500 Family	
Out of pocket maximum	In network: None; Out of network \$1,500 individual /\$4,500 family	
Lifetime maximum	None	
Plan Benefits		
Preventive Healthcare Services	In-Network	Out Of Network
Well child visits	Covered in full	Covered in full
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 80%, subject to the deductible for one routine exam per year
+Adult immunizations	Covered in full	Covered at 80%, subject to the deductible
+Mammography	Covered in full	Covered at 80%, subject to the deductible
+Pap smear	Covered in full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered in full	Covered at 80%, subject to the deductible
Prostate cancer screening	Covered in full	Covered at 80%, subject to the deductible
Routine vision	\$40 copay for one routine exam every year. \$60 eyewear allowance available per year	Covered at 80%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year
+Colonoscopy	Preventive screening covered in full	Covered at 80%, subject to the deductible
Physician Office Services	In-Network	Out Of Network
Diagnostic office visits	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Diagnostic x-rays	\$40 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible
Allergy tests	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Allergy injections	Adult: \$25 copay per visit to your PCP; \$40 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$40 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Chemotherapy	\$25 copay per visit	Covered at 80%, subject to the deductible
Radiation therapy	\$40 copay per visit	Covered at 80%, subject to the deductible
Maternity Services	In-Network	Out Of Network
Prenatal and postpartum care	Covered in full	Covered at 80%, subject to the deductible
Hospital care for mom (including delivery)	Covered in full	Covered at 80%, subject to the deductible
Newborn nursery care	Covered in full	Covered at 80%, subject to the deductible
Prescription Drug	In-Network	Out Of Network
Short-term and maintenance drugs	\$5/\$35/\$70; \$0 copay for generics for children to age 19	Not covered

SB-C-18		
SimplyBlue Copay		
Inpatient Hospital Benefits	In-Network	Out Of Network
Hospital benefits	Subject to \$500 copay per admission for unlimited days	Covered at 80%, subject to the deductible.
Physician visits in the hospital	Covered in full	Covered at 80%, subject to the deductible
Inpatient physical rehabilitation	Subject to \$500 copay per admission for up to 60 days per year	Covered at 80%, subject to the deductible for up to 60 days per year
Surgery	Covered in full	Covered at 80%, subject to the deductible
Anesthesia	Covered in full	Covered in full
Emergency Care	In-Network	Out Of Network
Emergency room care	\$250 copay per visit, unless admitted within 24 hours	\$250 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	\$40 copay per visit	Covered at 80%, subject to the deductible
Ambulance	\$250 copay	\$250 copay
Outpatient Hospital Benefits	In-Network	Out Of Network
Diagnostic x-rays	\$40 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible
Surgical care	\$250 copay	Covered at 80%, subject to the deductible
Chemotherapy	\$25 copay per visit	Covered at 80%, subject to the deductible
Radiation Therapy	\$40 copay per visit	Covered at 80%, subject to the deductible
Mental Health and Chemical Dependence	In-Network	Out Of Network
Inpatient mental health care	Subject to \$500 copay per admission for up to 30 days per year	Covered at 80%, subject to the deductible for up to 30 days per year
Outpatient mental health care	\$40 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office.	Covered at 80%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office
Inpatient chemical dependence	Subject to \$500 copay per admission for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime
Outpatient chemical dependence	\$40 copay per visit for up to 60 visits per year	Covered at 80%, subject to the deductible for up to 60 visits per year
Other Services	In-Network	Out Of Network
Diabetic insulin and supplies	\$25 copay for up to a 30 day supply	Covered at 80%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Subject to \$500 copay per admission for up to 45 days per year	Covered at 80%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year	Covered at 80%, subject to a \$50 deductible for up to 40 visits per year.
Hospice	Covered in full for unlimited visits	Covered at 80%, subject to the deductible for unlimited visits per year
Outpatient therapy	\$40 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy
Durable medical equipment	Covered at 50%	Covered at 50% subject to the deductible
External prosthetics	Covered at 50%	Covered at 50% subject to the deductible
Chiropractic	\$40 copay per visit	Covered at 80%, subject to the deductible
Acupuncture	\$40 copay for up to 10 visits per year	Covered at 80%, subject to the deductible, for up to 10 visits per year
Dental	\$40 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	\$40 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	Covered at 80%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.