

## BlueCross BlueShield Medical PPO Plans

Coverage	Basic PPO		Basic Plus PPO	
	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
Annual Deductible				
■ Individual	\$500	\$1,000	\$375	\$750
■ Family	\$1,000	\$2,000	\$750	\$1,500
Out-of-Pocket Maximum (including deductible)				
■ Individual	\$2,000	\$4,000	\$1,500	\$3,000
■ Family	\$4,000	\$8,000	\$3,000	\$6,000
Physician's Office Visits Primary Specialist	\$20 copay \$45 copay	40% after deductible 40% after deductible	\$20 copay \$35 copay	30% after deductible 30% after deductible
Outpatient Diagnostics (including X-rays, lab work, etc)	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Well-Child Care	\$0	40% after deductible	\$0	30% after deductible
Adult Preventive Care Vision & Hearing Exam	\$0	40% after deductible	\$0	30% after deductible
Hospital Care Inpatient Outpatient	20% after deductible 20% after deductible	40% after deductible 40% after deductible	\$300 copay + 10% after deductible \$150 copay + 10% after deductible	30% after deductible 30% after deductible
Emergency Treatment Emergency Room Urgent Care Ambulance Service	\$100 copay \$45 copay 20% after deductible	\$100 copay \$45 copay 20% after deductible	\$100 copay \$35 copay 10% after deductible	\$100 copay \$35 copay 10% after deductible
Physical/Speech and Occupational Therapies Up to 60 visits combined Speech – 30 visits	\$45 copay	40% after deductible	\$35 copay	30% after deductible
Chiropractic – 30 visits per year	\$45 copay	40% after deductible	\$35 copay	30% after deductible

*For a complete list of covered services, please refer to your "Summary Plan Description."*