Small Group Blue Open Access HMO Plans

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			3004AX	3005AX	3006AX	3007AX	3502AX	3501AX
Lifetime Maximum		In-network	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible	Individual	In-network	$0	$500	$1,000	$1,500	$1,000	$1,000
(up to three family members)	Family	In-network	$0	$1,500	$3,000	$4,500	$3,000	$3,000
Coinsurance		In-network	100%	100%	100%	100%	80%	80%
Calendar Year Out-of-Pocket Maximum	Individual	In-network	$0	$0	$0	$0	$2,000	$2,000
(in addition to the Calendar Year Deductible)	Family	In-network	$0	$0	$0	$0	$6,000	$6,000
Physician Office Visit PCP/SPC *(includes x-ray and lab work in office)*		In-network copay	$25/$35	$25/$35	$40/$50	$40/$50	$25/$35	$40/$50
Outpatient Diagnostic X-ray/Lab		In-network	100%	100%	100%	100%	80%	80%
Outpatient Surgical Facility/ Ambulatory Surgery Center		In-network	$100 copay; 100%	$100 copay; 100%	$100 copay; 100%	$100 copay; 100%	80%	$500 copay; 80%
Physician Outpatient Services *(surgeon, anesthesiologist, radiologist, etc.)*		In-network	100%	100%	100%	100%	80%	80%
Maternity *(physician fee only)*	*(1st visit only)*	In-network copay	$35	$35	$50	$50	$100	$500
Hospital Inpatient Services		In-network	100%	100%	100%	100%	80%	$500 copay per admission; 80%
Physician Inpatient Hospital Services		In-network	100%	100%	100%	100%	80%	80%
Physical and Occupational Therapy		In-network copay	$35	$35	$50	$50	$35	$50
(combined specialties)		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Chiropractic Care		In-network copay	$15	$15	$15	$15	$15	$15
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Behavioral Health/Substance Abuse	Inpatient	In-network	100%	100%	100%	100%	80%	$500 copay per admission; 80%
		Calendar year max	30 days	30 days	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	$35	$35	$50	$50	$35	$50
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Intermediate Level Behavioral Health - Partial Hospitalization Program/Intensive Outpatient		In-network	N/A	N/A	N/A	N/A	80%	N/A
		Calendar year max	N/A	N/A	N/A	N/A	5 days/visits	N/A
Emergency Room	Copay*	In-network	$100	$100	$100	$100	$100	$150
Prescription Drug Copays		Calendar year deductible per member	$0	$0	$0	$0	$0	$0
		Generic Formulary	$20	$20	$20	$20	$15	$20
		Brand Formulary	$35	$35	$35	$35	$30	$35
		Non-Formulary	$60	$60	$60	$60	$60	$60
		Mail Order Generic/Brand	$60/$60	$60/$60	$60/$60	$60/$60	$30/$60	$60/$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.
There are no benefits when services are received at an out-of-network hospital, physician, or other health care provider.
* ER copay is waived if admitted to the hospital.

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Small Group Blue Open Access HMO Plans, *continued pg. 2*

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			3503AX	3802AX	3801AX
Lifetime Maximum		In-network	Unlimited	Unlimited	Unlimited
Calendar Year Deductible *(up to three family members)*	Individual Family	In-network In-network	\$2,000 \$6,000	\$3,000 \$9,000	\$2,000 \$6,000
Coinsurance		In-network	80%	70%	70%
Calendar Year Out-of-Pocket Maximum *(in addition to the Calendar Year Deductible)*	Individual Family	In-network In-network	\$2,000 \$6,000	\$3,000 \$9,000	\$3,000 \$9,000
Physician Office Visit PCP/SPC *(includes x-ray and lab work in office)*		In-network copay	\$25/\$35	\$25/\$35	\$40/\$50
Outpatient Diagnostic X-ray/Lab		In-network	80%	70%	70%
Outpatient Surgical Facility/ Ambulatory Surgery Center		In-network	80%	70%	\$1,000 copay; 70%
Physician Outpatient Services *(surgeon, anesthesiologist, radiologist, etc.)*		In-network	80%	70%	70%
Maternity *(physician fee only)*	*(1st visit only)*	In-network copay	\$100	\$150	\$1,000
Hospital Inpatient Services		In-network	80%	70%	\$1,000 copay per admission; 70%
Physician Inpatient Hospital Services		In-network	80%	70%	70%
Physical and Occupational Therapy *(combined specialties)*		In-network copay Calendar year max	\$35 20 visits	\$35 20 visits	\$50 20 visits
Chiropractic Care		In-network copay Calendar year max	\$15 20 visits	\$15 20 visits	\$15 20 visits
Behavioral Health/Substance Abuse	Inpatient Outpatient	In-network Calendar year max In-network copay Calendar year max	80% 30 days \$35 20 visits	70% 30 days \$35 20 visits	\$1,000 copay per admission; 70% 30 days \$50 20 visits
Intermediate Level Behavioral Health - Partial Hospitalization Program/Intensive Outpatient		In-network Calendar year max	80% 5 days/visits	70% 5 days/visits	N/A N/A
Emergency Room	Copay*	In-network	\$100	\$150	\$150
Prescription Drug Copays		Calendar year deductible per member Generic Formulary Brand Formulary Non-Formulary Mail Order Generic/Brand	\$0 \$15 \$30 \$60 \$30/\$60	\$0 \$15 \$30 \$60 \$30/\$60	\$250 \$20 \$35 Not Cov. \$60/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.
There are no benefits when services are received at an out-of-network hospital, physician, or other health care provider.
* ER copay is waived if admitted to the hospital.

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