



HEALTH INSURANCE BENEFITS COMPARISON

BENEFITS EFFECTIVE 7-1-2022

Information is illustrative only. While every effort was taken to accurately report benefits, in case of a discrepancy between this Comparison and the actual plan documents, the actual plan documents will prevail. Please refer to the carrier's materials for a more complete description.

	Blue Advantage HMO	Blue Choice POS	
	In Network Only	In Network	Out of Network
Provider Network	Requires designation of a Primary Care Provider (PCP)	Requires designation of a Primary Care Provider (PCP)	
Benefit Period Deductible			
Single	\$500 Single	\$1,000 Single	
Family	\$1,000 Family	\$2,000 Family	
Out of Pocket Maximum			
Single	\$1,000 Single	\$2,000 Single	
Family	\$2,000 Family	\$4,000 Family	
Coinsurance	20%	20%	40%
Office Visit Services			
Physician Office/Urgent Care	\$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Specialist	\$35 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Preventative Care	100% covered if seen by PCP	100% covered if seen by PCP	Not Covered
Inpatient Hospital Services	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Physician Services	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital Services	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Services	See SBC for out-of-network coverage details		
Physician Office/Urgent Care	\$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Chiropractic Care	\$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Maternity Care/Delivery			
Office visits	100% covered	100% covered	40% coinsurance after deductible
Childbirth Professional Services	100% covered	100% covered	40% coinsurance after deductible
Childbirth Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Mental Health/Chemical Dependency			
Office Services	\$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Inpatient/Outpatient	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Vision Exam			
Routine Eye Exam (1 per calendar year)	\$35 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	Not Covered
Prescription Drug - BlueRX Value Plus			
Out of Pocket Max	\$3,000 Single / \$6,000 Family	\$3,000 Single / \$6,000 Family	
Tier 1	\$8 copay	\$8 copay	\$8 copay
Tier 2	\$20 copay	\$20 copay	\$20 copay
Tier 3	\$40 copay	\$40 copay	\$40 copay
Specialty	\$100 copay	\$100 copay	Not Covered