

Options BlueSM plan highlights

Coverage effective from 4/1/11 to 3/31/12

For the health of all.

Plan highlights apply to plans with the following group numbers: YA416, YA417, YA418, YA419, YA420, YA423

	Options Blue 80		Options Blue 100	
In-network plan features				
Calendar-year deductible options Family deductible can be met by any combination of family members and must be met before any benefits are paid (combines medical and drug expenses)	(a) \$1,500/single (b) \$2,200/single	(a) \$3,000/family (b) \$4,400/family	(a) \$2,700/single (b) \$3,700/single (c) \$4,700/single (d) \$6,000/single	(a) \$5,400/family (b) \$7,400/family (c) \$9,400/family (d) \$12,000/family
Out-of-pocket (OOP) maximum After this amount is reached, your plan pays 100% of covered expenses (combines medical and drug expenses)	(a) \$3,000/single (b) \$4,400/single	(a) \$6,000/family (b) \$8,800/family	(a) \$2,700/single (b) \$3,700/single (c) \$4,700/single (d) \$6,000/single	(a) \$5,400/family (b) \$7,400/family (c) \$9,400/family (d) \$12,000/family
Coinsurance Percentage that you pay after deductible	You pay 20% after deductible		You pay 0% after deductible	
Lifetime maximum	Unlimited		Unlimited	
In-network benefits				
Prescription drugs (GenRx formulary) 31-day supply. 90-day supply available through 90dayRx program at participating retail pharmacies or by PrimeMail ¹	Covered Preferred drug: You pay 20% after deductible Non-preferred drug: No coverage		Covered Preferred drug: You pay 0% after deductible Non-preferred drug: No coverage	
Physician services • Office or urgent care visits for illness or injury • Retail health clinic	Covered • You pay 20% after deductible • You pay 20% after deductible		Covered • You pay 0% after deductible • You pay 0% after deductible	
Inpatient/outpatient lab and diagnostic imaging/X-ray services	Covered You pay 20% after deductible		Covered You pay 0% after deductible	
Emergency care • Outpatient facility services • Outpatient professional services				
Inpatient/outpatient hospital services				
Ambulance				
Medical supplies				
Chiropractic care No maximum				
Physical, occupational, speech therapy No maximum				
Home health care Maximum of 180 visits per person per calendar year				
Preventive care/prenatal care/well-child care	You pay 0% (no deductible)		You pay 0% (no deductible)	
Maternity labor, delivery, post-delivery care and maternity complications	First 18 months: No coverage 19th month and after: You pay 20% after deductible		First 18 months: No coverage 19th month and after: You pay 0% after deductible	
Out-of-network plan features				
Calendar-year deductible Separate from in-network deductible (combines medical and drug expenses)	(a) \$3,000/single (b) \$4,400/single	(a) \$6,000/family (b) \$8,800/family	(a) \$5,400/single (b) \$7,400/single (c) \$9,400/single (d) \$12,000/single	(a) \$10,800/family (b) \$14,800/family (c) \$18,800/family (d) \$24,000/family
Out-of-pocket (OOP) maximum Separate from in-network OOP maximum (combines medical and drug expenses)	(a) \$6,000 per person (b) \$8,800 per person		(a) \$10,800 per person (b) \$14,800 per person (c) \$18,800 per person (d) \$24,000 per person	
Coinsurance	You pay 40% after deductible		You pay 20% after deductible	
Chiropractic care Maximum of 15 services per calendar year	You pay 40% after deductible		You pay 20% after deductible	
Physical, occupational, speech therapy Combined maximum of 15 services per calendar year	You pay 40% after deductible		You pay 20% after deductible	

When you choose a network provider you will receive the highest benefit levels and the lowest out-of-pocket costs. If you receive services from a nonparticipating provider, you will be responsible for: any deductibles or coinsurance plus the DIFFERENCE between what Blue Cross would reimburse for the nonparticipating provider and the actual charges the nonparticipating provider bills. This difference does not apply to your out-of-pocket maximum. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on Blue Cross' allowed amount, which is typically lower than the amount billed by the provider.

This is only a summary. Your contract will provide a detailed description of what is and is not covered. Services not covered include custodial care or rest cures, bariatric surgery, infertility, intensive behavioral therapy programs for treatment of autism spectrum disorders, eyewear, dental services, services that are experimental, not medically necessary or received while on military duty. Preexisting conditions you had during the six months before your enrollment date are not covered except for individuals under age 19. This limit applies for 12 months. Prior continuous coverage without a gap in coverage greater than 63 days counts toward reducing the 12-month period.

Deductible, copays and out-of-pocket maximums are subject to adjustments at our annual renewal based on Consumer Price Index.

¹PrimeMail is a mail-service pharmacy owned and operated by Prime Therapeutics LLC, an independent company providing pharmacy benefit management services.