

**Blue Point II Value**

**Blue Point II HDHP**

**Cost Sharing Expenses**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Deductible - Single	\$0	\$750		\$1,800	\$3,600	
Deductible - Family	\$0	\$2,250		\$3,600	\$7,200	
Coinsurance	0%	20%		10%	20%	
Annual Out of Pocket Maximum - Single	\$4,200	\$4,200		\$3,600	\$7,200	
Annual Out of Pocket Maximum - Family	\$12,600	\$12,600		\$7,200	\$14,400	
Annual Out of Pocket Maximum - Per Person Cap	N/A	N/A		\$6,650	\$14,400	

**Office Visit Cost Shares**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cost Share - Primary Care	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	N/A	N/A Subject to Deductible		N/A	N/A	

**Plan Limits**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No			Applies

**Who is Covered**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Domestic Partner Coverage			Not Covered			Not Covered

**Inpatient Facility**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Services	\$100 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	\$100 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	\$100 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	\$100 Copayment	20% Coinsurance Subject to Deductible	120 Days per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Days Per year
Physical Rehabilitation	\$100 Copayment	20% Coinsurance Subject to Deductible	60 Days per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	60 Days Per year
Maternity Care	\$100 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

**Inpatient Professional Services**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	10% Coinsurance Subject to \$1,800 Deductible	

**Outpatient Facility Services**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	\$50 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Radiation Therapy	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	Inclusive of Primary Service	Inclusive of Primary Service		Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Care	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

## Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	Covered in Full	20% Coinsurance Subject to \$50 Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to \$50 Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

## Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

## Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Radiation Therapy	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy Services	PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Telehealth	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - \$10 Copayment	Not Covered		PCP / Specialist - 10% Coinsurance Subject to Deductible	Not Covered	
Chiropractic Care	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - \$20 Copayment	Not Covered	1 Exam per calendar year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year

## Outpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	\$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Occupational Rehabilitation	\$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	\$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year

**Outpatient Professional Services**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Occupational Rehabilitation	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year

**Preventive Professional Services Meeting Federal Guidelines\***

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

**Preventive Facility Services Meeting Federal Guidelines\***

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

**Preventive services in addition to those required under Federal Guidelines - Professional**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prostate Cancer Screening	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

**Preventive services in addition to those required under Federal Guidelines - Facility**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	\$50 Copayment	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	\$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

**Additional Benefits**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Treatment of Diabetes - Insulin	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance	20% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - \$20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	10 Visits per contract year
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

**Diagnoses**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Reimbursement for Travel and Lodging Expenses	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

**ER Facility**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Facility Emergency Room Visit	\$50 Copayment	\$50 Copayment		10% Coinsurance Subject to Deductible	10% Coinsurance Subject to \$1,800 Deductible	

**Transportation**

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prehospital Emergency and Transportation - Ground or Water	\$50 Copayment	\$50 Copayment		10% Coinsurance Subject to Deductible	10% Coinsurance Subject to \$1,800 Deductible	

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

\* For non-grandfathered groups, Preventive Services coverage required by the 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 Patient Protection and Affordable Care Act requirements.

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### Urgent Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Urgent Care Center Facility Visit	\$25 Copayment	\$25 Copayment		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

### Vision

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Pediatric Eye Exams - Routine	\$20 Copayment	Not Covered	1 Exam per calendar year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	20% Coinsurance	Not Covered	1 Pair per calendar year	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	\$20 Copayment	Not Covered	1 Exam every 2 calendar years	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Covered	Not Covered	\$60 Reimbursement every 2 calendar years	Not Covered	Not Covered	Not Covered

### Rx Plan

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Rx Plan			\$10/\$25/\$40			\$5/\$35/\$70, \$0 Gen for Kids Integrated Rx, Preventive Rx

### Rx Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Days Supply Per Retail Order	30			30		
Days Supply Per Mail Order	90			90		
Copays Per Mail Order Supply	3			2		

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