

# Personal Blue<sup>SM</sup> plan highlights

Coverage effective date on or after 4/1/12

Plan highlights apply to plans with the following group numbers: YB001, YB002, YB003, YB004, YB005, YB006, YB007, YB008, YB009, YB010, YUM30, YUM31, YUM32



For the health of all.

	Personal Blue 80 with copay	Personal Blue 80	Personal Blue 100
<b>In-network plan features</b>			
<b>Calendar-year deductible options</b> No member can contribute more than the "per person" amount toward a family deductible. Family amount is for a family of 3 or more (combines medical and drug expenses).	(a) \$1,000/person – \$3,000/family (b) \$3,000/person – \$9,000/family	(a) \$1,500/person – \$4,500/family (b) \$2,500/person – \$7,500/family (c) \$3,500/person – \$10,500/family (d) \$4,500/person – \$13,500/family	(a) \$4,000/person – \$12,000/family (b) \$7,500/person – \$22,500/family (c) \$10,000/person – \$30,000/family (d) \$15,000/person – \$45,000/family
<b>Out-of-pocket (OOP) maximum</b> After this amount is reached, your plan pays 100% of covered expenses. Copays do not apply to out-of-pocket maximum. Family amount is for a family of 3 or more (combines medical and drug expenses).	(a) \$2,000/person – \$4,000/family (b) \$6,000/person – \$12,000/family	(a) \$3,000/person – \$6,000/family (b) \$4,500/person – \$9,000/family (c) \$6,000/person – \$12,000/family (d) \$7,000/person – \$14,000/family	(a) \$4,000/person – \$12,000/family (b) \$7,500/person – \$22,500/family (c) \$10,000/person – \$30,000/family (d) \$15,000/person – \$45,000/family
<b>Coinsurance</b> Percentage that you pay after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 0% after deductible
<b>Lifetime maximum</b>	Unlimited	Unlimited	Unlimited
<b>In-network benefits</b>			
<b>Prescription drugs (GenRx formulary)</b> 31-day supply. 90-day supply available through 90dayRx program at participating retail pharmacies or by PrimeMail <sup>1</sup>	<b>Covered</b> • Preferred generic: \$10 copay • Preferred brand: You pay 20% after deductible • Non-preferred drug: No coverage	<b>Covered</b> • Preferred generic: \$10 copay • Preferred brand: You pay 20% after deductible • Non-preferred drug: No coverage	<b>Covered</b> • Preferred drug: You pay 0% after deductible • Non-preferred drug: No coverage
<b>Physician services</b> • Office or urgent care visits for illness or injury  • Retail health clinic	<b>Covered</b> • \$50 copay per visit plus 20% after deductible for related services such as lab, X-rays, in-office surgery, allergy services • \$15 copay per visit plus 20% after deductible for related services as described above	<b>Covered</b> • You pay 20% after deductible plus 20% after deductible for related services such as lab, X-rays, in-office surgery, allergy services • You pay 20% coinsurance (no deductible) plus 20% after deductible for related services as described above	<b>Covered</b> You pay 0% after deductible
<b>Inpatient/outpatient lab and diagnostic imaging/X-ray services</b>	<b>Covered</b> You pay 20% after deductible	<b>Covered</b> You pay 20% after deductible	<b>Covered</b> You pay 0% after deductible
<b>Emergency care</b> • Outpatient facility services • Outpatient professional services			
<b>Inpatient/outpatient hospital services</b>			
<b>Ambulance</b>			
<b>Medical supplies</b>			
<b>Chiropractic care</b> No maximum			
<b>Physical, occupational, speech therapy</b> No maximum			
<b>Home health care</b> Maximum of 180 visits per person per calendar year			
<b>Mental health/substance abuse</b> <i>You have an option to remove mental health and substance abuse coverage. Removing coverage will decrease your monthly premium.</i>			
<b>Preventive care/prenatal care/well-child care</b>	You pay 0% (no deductible)	You pay 0% (no deductible)	You pay 0% (no deductible)
<b>Maternity labor, delivery, post-delivery care and maternity complications</b>	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 20% after deductible	First 18 months: No coverage 19th month and after: You pay 0% after deductible
<b>Out-of-network plan features</b>			
<b>Calendar-year deductible</b> Separate from in-network deductible (combines medical and drug expenses)	(a) \$2,000/person – \$6,000/family (b) \$6,000/person – \$18,000/family	(a) \$3,000/person – \$9,000/family (b) \$5,000/person – \$15,000/family (c) \$7,000/person – \$21,000/family (d) \$9,000/person – \$27,000/family	(a) \$8,000/person – \$24,000/family (b) \$15,000/person – \$45,000/family (c) \$20,000/person – \$60,000/family (d) \$30,000/person – \$90,000/family
<b>Out-of-pocket (OOP) maximum</b> Separate from in-network OOP (combines medical and drug expenses)	(a) \$4,000/person (b) \$12,000/person	(a) \$6,000/person (b) \$10,000/person (c) \$14,000/person (d) \$18,000/person	(a) \$16,000/person (b) \$30,000/person (c) \$40,000/person (d) \$60,000/person
<b>Coinsurance</b>	You pay 40% after deductible	You pay 40% after deductible	You pay 20% after deductible
<b>Chiropractic care</b> Maximum of 15 services per calendar year	You pay 40% after deductible	You pay 40% after deductible	You pay 20% after deductible
<b>Physical, occupational, speech therapy</b> Combined maximum of 15 services per calendar year	You pay 40% after deductible	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.

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