Standard Plan vs. Preferred Plan

Plans As Of 7-1-18			Preferred In Network	Preferred Out of Network	Standard In Network	Standard Out of Network
Medical						
	Deductible					
		All Covered Services unless otherwise specified	$375.00	$575.00	$1,125.00	$1,725.00
		Family Deductible maximum	$1,125.00	$1,725.00	$3,375.00	$5,175.00
	Co-Insurance					
		All Facility Covered Services after Ded has been satisfied (unless otherwise specified)	90%	70%	70%	50%
		Professional Provider Covered Services after Ded has been satisfied (unless otherwise specified)	90%	70%	70%	50%
		Emergency Room Services	90% subject to Ded and coinsurance and a $200 Co-payment*	70% subject to Ded and coinsurance	70% subject to Ded and coinsurance and a $250 Co-payment*	70% subject to Ded and coinsurance and a $250 Co-payment*
		* Co-payments are waived if admitted to the Hospital as a bed patient and will not apply to any Deductible or Out of Pocket maximum.				
		All other covered services (unless otherwise specified)	80% subject to Ded and coinsurance	60% subject to Ded and coinsurance	70% subject to Ded and coinsurance	50% subject to Ded and coinsurance
		Preventive Services, e.g. Physical Exams, Routine Pap Smear, Prostate Exam, Mammograms (Statutory coverage)	100%	Preventive Services are not available.	100%	Preventive Services are not available.
	Out-of-Pocket Max					
		Individual	$2,575.00	$7,575.00	$6,850.00	UNLIMITED
		Family	$7,725.00	$15,150.00	$13,700.00	UNLIMITED
	Psychiatric Maximums					
		Inpatient	90% subject to Ded and coinsurance	70% subject to Ded and coinsurance	70% subject to Ded and coinsurance	50% subject to Ded and coinsurance
		Outpatient	90% subject to Ded and coinsurance	70% subject to Ded and coinsurance	70% subject to Ded and coinsurance	50% subject to Ded and coinsurance

Please See Other Side

Standard Plan vs. Preferred Plan

Plans As Of 7-1-18			Preferred In Network	Preferred Out of Network	Standard In Network	Standard Out of Network
	Organ Transplant					
		All except Kidney	**Blue Distinction Centers for Transplants (BDCT) Network:** 90% after Network Deductible, Network Out-of-Pocket Maximum applies. **Transplant Network:** 90% of the Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-pocket Maximum applies; amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.	70% of the Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not covered.	**Blue Distinction Centers for Transplants (BDCT) Network:** 70% after Network Deductible, Network Out-of-Pocket Maximum applies. **Transplant Network:** 70% of the Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-pocket Maximum applies; amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.	50% of the Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not covered.
		Kidney	90% after Network Deductible; Network Out-of-Pocket Maximum applies.	70% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not covered.	70% after Network Deductible; Network Out-of-Pocket Maximum applies.	50% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not covered.
RX						
		Drug Tier	**Preferred Plan Co-pay**	**Standard Plan Co-pay**	**One to One Clinic copay**	
		Generic	10%/$30 max	10%/$60 max	$0.00 if available	
		Preferred Brand	25%/$70 max	25%/$140 max	Not available	
		Non-Preferred Brand	35%/$120 max	35%/$240 max	Not available	
		All mail order is 2 times for prescriptions over 34 days if ordered through BlueCross. Any mailing charges, if applicable will also apply.				

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