

	BLUE SHIELD EPO OPTIONS	
	LOW OPTION EPO	HIGH OPTION EPO
PLAN BENEFITS		
DEDUCTIBLE	None	None
PLAN LIFETIME MAXIMUM	Unlimited	Unlimited
OUT-OF-POCKET MAXIMUM Individual/Family	\$1,500 Individual /\$3,000 Family	\$1,500 Individual/\$3,000 Family
OFFICE VISITS	\$20 Copay - Physician \$20 Copay - Specialist	\$15 Copay - Physician \$15 Copay - Specialist
PRESCRIPTION DRUG (Administered by Medco)	\$25 annual deductible for Preferred and Non-Preferred Brand \$10 Generic \$35 Preferred Brand \$50 Non-Preferred Brand (30-day supply)	\$25 annual deductible for Preferred and Non-Preferred Brand \$10 Generic \$30 Preferred Brand \$45 Non-Preferred Brand (30-day supply)
PRESCRIPTION DRUG - MAIL ORDER (Administered by Medco)	\$25 annual deductible for Preferred and Non-Preferred Brand \$20 Generic \$70 Preferred Brand \$100 Non-Preferred Brand (90-day supply)	\$25 annual deductible for Preferred and Non-Preferred Brand \$20 Generic \$60 Preferred Brand \$90 Non-Preferred Brand (90-day supply)
EMERGENCY SERVICES	\$100 Copay (waived if admitted)	\$50 Copay (waived if admitted)
CHIROPRACTIC	\$20 Copay (up to 30 visits per calendar year)	\$15 Copay (up to 30 visits per calendar year)
ACUPUNCTURE	\$20 Copay (up to 12 visits per calendar year)	\$15 Copay (up to 12 visits per calendar year)
PREVENTIVE CARE	No Charge	No Charge
OUTPATIENT LAB & X-RAY	No Charge	No Charge
HOSPITAL SERVICES Inpatient	\$250/Admit + 20%	\$100/Admit
Outpatient	No Charge	No Charge
SUBSTANCE ABUSE PROGRAM Inpatient	\$250/Admit + 20%	\$100/Admit
Outpatient	\$20 Copay	\$15 Copay
MENTAL HEALTH Inpatient	\$250/Admit + 20%	\$100/Admit
Outpatient	\$20 Copay	\$15 Copay

The information in this summary is not intended to take the place of, or change the official Plan Documents or Evidence of Coverage. In the event that the information in this brochure differs from the Plan Document, the Plan Document shall prevail.