

	<b>BLUE SHIELD - PPO</b>	
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>PLAN BENEFITS</b>		
<b>DEDUCTIBLE</b> Individual/Family	\$500 Individual/\$1,500 Family	\$500 Individual/\$1,500 Family
<b>PLAN LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>Out-Of-POCKET MAXIMUM</b> Individual/Family	\$4,000 / \$8,000	\$6,000/ \$12,000
<b>OFFICE VISITS</b>	\$30 Copay - Physician \$30 Copay - Specialist	40% - Physician 40% - Specialist
<b>PRESCRIPTION DRUG</b> (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 \$35 Preferred Brand \$50 Non-Preferred Brand (30-day supply)
<b>PRESCRIPTION DRUG - MAIL ORDER</b> (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 \$70 Preferred Brand \$100 Non-Preferred Brand (90-day supply)
<b>EMERGENCY SERVICES</b>	\$75/visit + 20% (waived if admitted)	\$75/visit + 20% (waived if admitted)
<b>CHIROPRACTIC</b>	\$30 Copay (up to 12 visits per calendar year)	Not Covered
<b>ACUPUNCTURE</b>	20% (up to 12 visits per calendar year)	20%
<b>PREVENTIVE CARE</b>	<b>No Charge</b>	40%
<b>OUTPATIENT LAB &amp; X-RAY</b>	20%	40%
<b>HOSPITAL SERVICES</b> Inpatient	\$250/Admit + 20%	40%
Outpatient	20%	40%
<b>SUBSTANCE ABUSE PROGRAM</b> Inpatient	\$250/Admit + 20%	40%
Outpatient	\$30 Copay	40%
<b>MENTAL HEALTH</b> Inpatient	\$250/Admit + 20%	40%
Outpatient	\$30 Copay	40%

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.