2022-2023	Blue Shield	Blue Shield	Blue Shield	Blue Shield
BLUE SHIELD	**100-C $20**	**90-C $20**	**80-G $30**	**HSA-B**
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$200/$400	$200/$500	$500/$1,000	$3,000/$5,200*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$5,000/$10,000*
				*Includes Rx
PROFESSIONAL SERVICES				
Office Visit (OV) co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$20	$20	$30	Deductible, then 10%
Urgent Care co-pay	$20	$20	$30	10%
Specialists/Consultants co-pay	$20	$20	$30	10%
Prenatal, postnatal office visit co-pay	$20	$20	$30	10%
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	10%
Diagnostic X-ray & Laboratory Procedures	0%	10%	20%	10%
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES				
Emergency Room visit (copay waived if admitted)	0% $100 co-pay	10% $100 co-pay	20% $100 co-pay	10% $100 co-pay
Inpatient Hospital (preauthorization required) - limits may apply	0%	10%	20%	10%
Outpatient Hospital	0%	10%	20%	10%
Surgery, Outpatient (performed in Surgery Center)	0%	10%	20%	10%
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	10%	20%	10%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT				
INPATIENT: Facility Based Care (preauth required)	0%	10%	20%	10%
OUTPATIENT: Facility Based Care (preauth required)	0%	10%	20%	10%
OTHER SERVICES				
Ambulance (Ground or Air)	0% $100 co-pay	10% $100 co-pay	20% $100 co-pay	10% $100 co-pay
Acupuncture - Limits apply	0%	10%	20%	10%
Chiropractic - Limits apply	0%	10%	20%	10%
Durable Medical Equipment (DME)	0%	10%	20%	10%
Physical and Occupational Therapy - Limits apply	0%	10%	20%	10%
Hearing Aids	Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months
PHARMACY BENEFITS PLAN	**7-25**	**7-25**	**7-25**	**9-35**
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$1,500/$2,500	$1,500/$2,500	$2,500/$3,500
Generic co-pay/30 days supply	$0 at Costco $7 at Other Network	$0 at Costco $7 at Other Network	$0 at Costco $7 at Other Network	$0 at Costco $9 at Other Network
Brand co-pay/30 days supply	$25	$25.00	$25.00	$35.00
Specialty co-pay/up to 30 days supply	$25 Must Use Navitus Mail	$25 Must Use Navitus Mail	$25 Must Use Navitus Mail	$35 Must Use Navitus Mail
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$60	$0-$60	$0-$60	$0-$90
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy