

COMPARE THE BENEFITS PROVIDED BY EACH OF OUR DIRECT PAY PROGRAMS

Benefit Description	CompleteCare SM Comprehensive Major Medical	PPOBlue SM Individual Comprehensive Major Medical Preferred-Provider High-Deductible Program		DirectBlue [®] Individual Preferred-Provider Program		KeystoneBlue SM Individual HMO
Type of Program	A program that combines hospital, medical/surgical and Major Medical benefits.	A qualified high-deductible health plan designed for use with a Health Savings Account as defined by the Internal Revenue Service.		A program that provides coverage for services received in the network at the higher level and out of the network at the lower level.		A managed care program that requires you to choose a primary care physician to provide preventive care and to use network providers for all care.
Benefit Period	Contract year; calendar year for prescription drugs	Contract year, including prescription drugs		Contract year; calendar year for prescription drugs		Calendar year, including prescription drugs
Pre-Existing Conditions Limitation	For the first 12 months of coverage, program will not pay expenses related to a condition for which you received medical advice/attention during the five years before you enrolled.	For the first 12 months of coverage, program will not pay expenses related to a condition for which you received medical advice/attention during the five years before you enrolled.		For the first 12 months of coverage, program will not pay expenses related to a condition for which you received medical advice/attention during the five years before you enrolled.		For the first 12 months of coverage, program will not pay expenses related to a condition for which you received medical advice/attention during the five years before you enrolled.
Deductible	Your choice of deductible: Individual/Family—\$500/\$1,500; \$1,000/\$3,000	Network	Out-of-Network	Network	Out-of-Network	None
		Your choice of deductible: Individual/Family—\$1,200/\$2,400; \$2,600/\$5,200; \$3,500/\$7,000		Individual/Family—\$250/\$750	Individual/Family—\$500/\$1,500	
Out-of-Pocket Maximum	\$1,000 per individual with \$3,000 maximum per family	Individual/Family—\$1,000/\$2,000; \$1,200/\$2,400; \$1,500/\$3,000	Double the network amounts	Individual/Family—\$1,500/\$4,500		None
Benefit Period Maximum	\$1,000,000 per individual with a separate \$50,000 maximum for prescription drugs	\$1,000,000 per individual including out-of-network payments and a separate \$50,000 maximum for prescription drugs		\$1,000,000 per individual combined for network and out of network and a separate \$50,000 maximum for prescription drugs		\$1,000,000 per individual and a separate \$50,000 maximum for prescription drugs
Lifetime Maximum	\$5,000,000 excluding prescription drugs	\$5,000,000 including prescription drugs and out-of-network payments	\$300,000	\$5,000,000 excluding prescription drugs and including out-of-network payments	\$300,000	\$5,000,000 excluding prescription drugs
Copayment/Coinsurance	You pay 20% coinsurance up to out-of-pocket maximum, then paid at 100%	You pay 10% coinsurance up to out-of-pocket maximum, then paid at 100%	You pay 30% coinsurance up to out-of-pocket maximum, then paid at 100%	You pay 10% coinsurance up to out-of-pocket maximum, then paid at 100%	You pay 30% coinsurance up to out-of-pocket maximum, then paid at 100%	Covered 100% for most services after you pay copayments of \$10 for PCP office visits, \$15 for specialist office visits
Emergency Care	You pay 20% coinsurance	You pay 10% coinsurance		You pay \$40 copayment and 10% coinsurance		You pay \$35 copayment
Inpatient Services	No limit on days	No limit on days	90 days per benefit period	No limit on days	90 days per benefit period	Unlimited
Prescription Drugs	You pay \$100 deductible, then 20% coinsurance with \$10 minimum/\$100 maximum for generic and \$20 minimum/\$100 maximum for brand	After program deductible is met, you pay 10% of discounted cost up to out-of-pocket maximum	Not covered	You pay \$100 deductible, then 100% coverage with copayments of \$10 generic/\$20 brand	Not covered	You pay \$100 deductible, then 100% coverage with copayments of \$10 generic/\$20 brand
Outpatient Rehabilitation and Therapy Services	Physical medicine—15 visits per calendar year Combined occupational/speech therapy—15 visits per calendar year Spinal manipulation not covered	Physical medicine—15 visits per contract year Combined occupational/speech therapy—15 visits per contract year Spinal manipulation—10 visits per contract year		Physical medicine—15 visits per calendar year Combined occupational/speech therapy—15 visits per calendar year Spinal manipulation—10 visits per calendar year		Physical medicine—15 visits per calendar year Combined occupational/speech therapy—15 visits per calendar year Spinal manipulation—10 visits per calendar year