INDIVIDUAL PLANS COMPARISON CHART

COVERED BENEFITS	BLUE*SAVER*	BLUE *MAX*	POINT OF SERVICE PLANS 1–4 (POS)*	POINT OF SERVICE PLAN 5 (POS)*	POS DEPENDENT OUT-OF-AREA*	BLUE*SELECT*	BLUE *VALUE*
Lifetime Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Benefit Period Deductible	$1,200 (single) $2,400 (family) $1,900 (single) $3,800 (family) $2,800 (single) $5,600 (family) $3,300 (single) $6,600 (family) $5,500 (single) $10,000 (family) Deductibles accrue to OOP maximum	$100; $250; $500; $750; $1,000; $2,500 or $5,000 (three per family)	Network: None Non-Network: $2,000 ($6,000 family)	Network: $1,000 ($3,000 family) Non-Network: $2,000 ($6,000 family)	$500 ($1,500 family)	$100; $250; $500; $750; $1,000; $2,500 or $5,000 Prescription Drugs: $2,500 (three per family)	$100; $250; $500; $750; $1,000; $2,500 or $5,000 (three per family)
Out-of-Pocket Maximums	$3,400 (single) $6,800 (family) $4,100 (single) $8,200 (family) $5,000 (single) $10,000 (family) $5,500 (single) $11,000 (family)	$2,000 (per member)	Plans 1, 2, 3 $1,500 ($3,000 family) Plan 4 $2,000 ($4,000 family)	$2,000 ($4,000 family)	$3,500 single ($7,000 family)	$1,000 Prescription Drugs: $1,000 (per member)	$1,000 (per member)
Coinsurance	Network PPO: 100%/0% or 80%/20% Non-Network: 80%/20% or 60%/40%	Network PPO: 80%/20% or 70%/30% Non-Network: 60%/40% or 50%/50%	Non-Network: 60%/40%	Non-Network: 60%/40%	80%/20%	Network PPO: 80%/20% Non-Network: 60%/40%	Network PPO: 80%/20% Non-Network: 60%/40%
Physician Office Visits	Deductible then coinsurance	Network PPO: 20% or $20 copayment with $100–$500 deductible; $50 copayment with $750–$2,500 deductible; all other plans: deductible then coinsurance	Network copayment options: $20 PCP / $40 specialist $25 PCP / $45 specialist $30 PCP / $50 specialist $35 PCP / $55 specialist Non-Network: deductible then coinsurance	Network: $35 PCP $55 specialist Non-Network: deductible then coinsurance	Deductible then coinsurance	No coverage	No coverage
Preventive & Wellness Office Visits	Network PPO: deductible and coinsurance waived. Non-Network: coinsurance	Network PPO: 100% or applicable copayment waived. Non-Network: coinsurance	Network: applicable copayment Non-Network: Coinsurance	Network: applicable copayment Non-Network: Coinsurance	100%	Network PPO: 100%/0% Non-Network: 60%/40%	Deductible waived for: • one routine PAP smear • one mammogram • one digital rectal exam • immunizations Deductible & coinsurance apply to: • one hemoccult (colon) test
Prescription Drugs (Mail-order: three copayments for a three-month supply)	(after deductible) Generic: 100%/0% or 80%/20% Brand-Name:80%/20% or 60%/40% Mental & Nervous: Generic: 80%/20% or 70%/30% Brand: 50%/50% Note: Based upon coinsurance amounts	Plans with $750 deductible or lower have five copayment levels: $7 $25 $45 $60 $50 Plans with $1,000 deductible or higher are subject to a separate pharmacy deductible	Five copayment levels: $7 $25 $45 $60 $50 ($500 deductible option also available)	Five copayment levels: $7 $25 $45 $60 $50 After $500 RX deductible	Five copayment levels: $7 $25 $45 $60 $50 ($500 deductible option also available)	(after $2,500 drug deductible) Generic: 80%/20% Brand: 50%/50% (after $1,000 drug out-of-pocket maximum) 100% coverage for brand and generic	No coverage (unless administered in hospital or outpatient facility for covered services)
Emergency Room Coverage	Deductible then coinsurance	Deductible then coinsurance	Network: $100 copayment (waived if admitted) Non-network: deductible then coinsurance	Network: $100 copayment (waived if admitted) Non-network: deductible then coinsurance	Deductible then coinsurance	(after deductible) Available only for accidental injuries or if visit results in inpatient stay	(after deductible) Available only for accidental injuries or if visit results in inpatient stay
Inpatient Hospital Admission	Deductible then coinsurance	Deductible then coinsurance	Network: $200, $250 or $300 copayment per day max x3 Non-network: deductible then coinsurance)	Network: Plan pays 100% after deductible Non-network: deductible then coinsurance)	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance
Ambulatory Surgical Center	Deductible then coinsurance	Deductible then coinsurance	Network: $200, $250 or $300 copayment Non-network: deductible then coinsurance)	Plan pays 100% after deductible	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance
Pregnancy Care Option	Coverage is same as any other condition	Available with $500 deductible or more; coverage is same as any other condition	No coverage	No coverage	No coverage	No coverage	No coverage

01MK1712 R01/10 *Offered through HMO Louisiana, Inc., and available in the Baton Rouge, New Orleans and Shreveport service areas; Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company