

	No Deductible Plan	\$750 Deductible Plan
Deductible	Single: None / Family: None	\$750/\$1500 (No one member will exceed \$750)
Out-of-Pocket Max	\$4000/\$8000 (No one member will exceed \$4000)	\$4000/\$8000 (No one member will exceed \$4000)
Office Visits	Annual \$0 copay PCP & Spec \$10 Allergy & Dermatology \$15	Annual \$0 copay PCP & Spec \$30 Allergy & Dermatology \$30
Hospital – Facility In-patient/Out-patient Medical/surgical	BCBS pays 100%	BCBS pays 100% after deductible
Emergency Room (Waived if admitted)	\$100 co-pay (Annual Max per year \$200 / \$300 family)	\$100 co-pay
Behavioral Health Mental Health & Chemical Dependency	Inpatient :100% / Office visits: \$10 co-pay	Inpatient 100% after deductible / Office visits: \$15 co-pay
Diagnostic Lab, x-ray, machine Tests, Imaging and Sleep studies	BCBS pays 100%	BCBS pays 100% after deductible
Vision	One Routine eye exam per calendar year \$10 co-pay	One Routine eye exam per calendar year (\$30 co-pay) + a maximum of \$100 reimbursement per benefit year towards the purchase of eyeglasses and/or frames and contact lenses