<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem BCBS BlueCard PPO 90</td>
<td>$500 per person</td>
<td>$1,000 per person</td>
<td>$2,500 per person</td>
<td>$5,000 per person</td>
<td>$7,500 per person</td>
<td>$2,500 per person</td>
<td>$10,000 per person</td>
<td>$20,000 per person</td>
<td>$5,000 per person</td>
<td>$10,000 per person</td>
</tr>
<tr>
<td>Anthem BCBS BlueCard PPO 80</td>
<td>$1,000 per person</td>
<td>$2,000 per family</td>
<td>$5,000 per person</td>
<td>$10,000 per family</td>
<td>$14,000 per family</td>
<td>$5,000 per person</td>
<td>$20,000 per family</td>
<td>$8,450 per family</td>
<td>$5,450 per family</td>
<td>$13,000 per family</td>
</tr>
<tr>
<td>Anthem BCBS BlueCard PPO 70</td>
<td>$2,000 per family</td>
<td>$2,000 per family</td>
<td>$7,000 per person</td>
<td>$14,000 per family</td>
<td>$17,000 per person</td>
<td>$14,000 per family</td>
<td>$20,000 per family</td>
<td>$8,450 per family</td>
<td>$6,000 per family</td>
<td>$13,000 per family</td>
</tr>
<tr>
<td>Anthem BCBS CDHP 20/HSA</td>
<td>$5,000 per person</td>
<td>$6,000 per family</td>
<td>$10,000 per person</td>
<td>$14,000 per family</td>
<td>$2,700 per person</td>
<td>$6,000 per family</td>
<td>$10,000 per person</td>
<td>$8,450 per family</td>
<td>$3,000 per person</td>
<td>$13,000 per family</td>
</tr>
</tbody>
</table>

**Preventive Care**
- Preventive Services & Well-Child Care: 50% coinsurance
- Physician Services:
  - Office Visit: $30 copay 50% coinsurance
  - Diagnostic Services (outpatient): 10% coinsurance 50% coinsurance
  - Specialist Care: $45 coinsurance 10% coinsurance
- Hospital Services:
  - Inpatient Services (including inpatient maternity services): 10% coinsurance 50% coinsurance
  - Outpatient Surgery: 10% coinsurance 50% coinsurance
- Emergency Room Care: $250 copay 50% coinsurance
- Ambulance Services: 10% coinsurance 50% coinsurance

**Mental Health/Substance Abuse**
- Outpatient Services: $30 copay 50% coinsurance
- Inpatient Services: 10% coinsurance 50% coinsurance

**Other Medical Services**
- Durable Medical Equipment: 10% coinsurance 50% coinsurance
- Home Care: 10% coinsurance 50% coinsurance
- Outpatient Therapy:
  - $30 copay PCP/$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
  - $30 copay PCP/$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
  - $30 copay PCP/$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
  - $30 copay PCP/$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
- Skilled Nursing / Acute Rehabilitation Facility: 10% coinsurance 50% coinsurance
- Urgent Care Services: $50 copay 50% coinsurance