JANUARY 1, 2025 - AUGUST 31, 2025

BCBS COMMUNITY BLUE PPO	Plan Choice #7 (HSA)		Plan Choice #8 (HSA)	
Plan Design	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible (Single/Family)	**$2,000/$4,000**	**$4,000/$8,000**	**$2,500/$5,000**	**$5,000/$10,000**
Office Visit / Urgent Care	**80% after deductible**	**60% after deductible**	**80% after deductible**	**60% after deductible**
Emergency Room	**80% after deductible**	**60% after deductible**	**80% after deductible**	**60% after deductible**
Preventive Care	**100% (not subject to deductible)**	**Not Covered**	**100% (not subject to deductible)**	**Not Covered**
Coinsurance	**80% after deductible**	**80% after deductible**	**80% after deductible**	**80% after deductible**
Coinsurance Maximum (Single/Family) Not Including Deductible	**N/A**	**N/A**	**N/A**	**N/A**
Prescription Drugs (copays for HSA plans apply after deductible is met)	**$15 Generic** **$50 Brand** **50% ($70 min/$100 max) Non Preferred Brand** **(Mail Order x 2)**	**75% of approved amount; plus copays**	**$15 Generic** **$50 Brand** **50% ($70 min/$100 max) Non Preferred Brand** **(Mail Order x 2)**	**75% of approved amount; plus copays**
Out-of-Pocket Maximum **In-Network includes applicable deductibles, coinsurance and copays. Out-of-Network excludes copays**	**$3,000 per member/$6,000 for 2 or more members per calendar year**	**$6,000 per member/$12,000 for 2 or more members per calendar year**	**$4,000 per member/$8,000 for 2 or more members per calendar year**	**$8,000 per member/$16,000 for 2 or more members per calendar year**
	MONTHLY COST		**MONTHLY COST**	
Single	**$28.95**		**$0.00**	
2-Person	**$60.57**		**$0.00**	
Family	**$78.85**		**$0.00**	