

## Comparison of benefits for RCSD

2025

type of care/plan features	Core Plan	Enhanced Plan	SimplyBlue Copay/Deductible
	Coverage*	Coverage*	Coverage*
<b>Plan features</b> <ul style="list-style-type: none"> <li>Primary Care Physician (PCP)</li> <li>Referrals</li> <li>Out of network benefits</li> <li>Out of area benefits</li> <li>Student/Dependent coverage</li> </ul>	<ul style="list-style-type: none"> <li>Not required</li> <li>Not required</li> <li>Not covered</li> <li>Coverage provided worldwide through the BlueCard® program.</li> <li>Qualified dependents and students are covered to age 26.</li> </ul>	<ul style="list-style-type: none"> <li>Not required</li> <li>Not required</li> <li>Not covered</li> <li>Coverage provided worldwide through the BlueCard® program.</li> <li>Qualified dependents and students are covered to age 26.</li> </ul>	<ul style="list-style-type: none"> <li>Not required</li> <li>Not required</li> <li>Not covered</li> <li>Coverage provided worldwide through the BlueCard® program.</li> <li>Qualified dependents and students are covered to age 26.</li> </ul>
<b>Plan cost-sharing highlights</b> <ul style="list-style-type: none"> <li>Office visit copay (Primary Care Physician)</li> <li>Office visit copay (Specialist)</li> <li>Coinsurance</li> <li>Deductible</li> <li>Out of pocket maximum</li> <li>Lifetime maximum</li> </ul>	<ul style="list-style-type: none"> <li>\$20 copay</li> <li>\$40 copay</li> <li>20%; Coinsurance Maximum: \$750 individual/\$2250 family</li> <li>\$250 individual/\$750 family</li> <li>\$6350 individual/\$12700 family</li> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>\$15 copay</li> <li>\$15 copay</li> <li>None</li> <li>None</li> <li>\$6350 individual/\$12700 family</li> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>\$25 copay subject to deductible</li> <li>\$40 copay subject to deductible</li> <li>None</li> <li>\$600 individual/\$1200 family</li> <li>\$4000 individual/\$8000 family</li> <li>None</li> </ul>
<b>Preventive Health Care Services</b> <ul style="list-style-type: none"> <li>Well child visits</li> <li>Adult routine physical exams</li> <li>Adult immunizations</li> <li>Mammography</li> <li>Pap smear</li> <li>Routine GYN exam</li> <li>Prostate cancer screening</li> <li>Routine vision</li> <li>Colonoscopy</li> </ul>	<ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full for 1 exam per year according to national guidelines</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>\$20 copay per visit with PCP, \$40 copay with specialist</li> <li>\$20 copay for one routine eye exam every year. \$60 eyewear allowance every year.</li> <li>Preventive covered in full</li> </ul>	<ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full for 1 exam per year according to national guidelines</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>\$15 copay</li> <li>\$15 copay for one routine exam per year; \$100 eyewear allowance available per year</li> <li>Preventive covered in full</li> </ul>	<ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full for 1 exam per year according to national guidelines</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in Full</li> <li>Not Covered</li> <li>Preventive covered in full</li> </ul>
<b>Physician Office Services</b> <ul style="list-style-type: none"> <li>Diagnostic office visits</li> <li>Diagnostic x-rays</li> </ul>	<ul style="list-style-type: none"> <li>\$20 copay per visit with PCP, \$40 copay per visits with specialist</li> <li>\$40 copay per visit. Precertification applies to MRI, PET and CAT scans.</li> </ul>	<ul style="list-style-type: none"> <li>\$15 copay per visit, \$0 for children to age 19 for PCP</li> <li>\$15 copay. Precertification applies to MRI, PET and CAT scans.</li> </ul>	<ul style="list-style-type: none"> <li>\$25 copay subject to deductible per visit, \$0 subject for children to age 19 for PCP</li> <li>\$40 copay subject to deductible. Precertification applies to MRI, PET and CAT scans.</li> </ul>

<ul style="list-style-type: none"> <li>• Diagnostic laboratory and pathology</li> <li>• Allergy tests</li> </ul>	<ul style="list-style-type: none"> <li>• \$20 copay per visit</li> <li>• \$20 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• \$15 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay subject to deductible.</li> <li>• \$40 copay subject to deductible.</li> </ul>
type of care/plan features	Core Plan	Enhanced Plan	SimplyBlue Copay/Deductible
	Coverage*	Coverage*	Coverage*
<ul style="list-style-type: none"> <li>• Allergy injections</li> <li>• Chemotherapy</li> <li>• Radiation therapy</li> <li>• Second Medical Opinion</li> <li>• Sick Child Visits</li> </ul>	<ul style="list-style-type: none"> <li>• \$20 copay per visit</li> <li>• \$40 copay per visit</li> <li>• \$40 copay per visit</li> <li>• \$40 copay per visit</li> <li>• \$20 copay per visit with PCP, \$40 copay with specialist</li> </ul>	<ul style="list-style-type: none"> <li>• \$15 copay per visit</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• \$15 copay per visit</li> <li>• \$0 to age 19</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay subject to deductible.</li> <li>• \$40 copay subject to deductible.</li> <li>• \$40 copay subject to deductible.</li> <li>• \$40 copay subject to deductible.</li> <li>• \$0 to age 19</li> </ul>
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Hospital care for mom (including delivery)</li> <li>• Newborn nursery care</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• Covered at 80%, subject to the deductible</li> <li>• Covered at 80%, subject to the deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay subject to deductible.</li> <li>• \$1000 copay subject to deductible.</li> <li>• Covered in full</li> </ul>
<b>Prescription Drug</b> <ul style="list-style-type: none"> <li>• Short-term and maintenance drugs</li> </ul>	<ul style="list-style-type: none"> <li>• \$10/\$30/\$50 for retail and mail order. Retail 2.5 copay for 90 day supply. Mail order 1 copays for 90 day supply</li> </ul>	<ul style="list-style-type: none"> <li>• \$5/\$20/\$35 for retail and mail order. Retail 2.5 copay for 90 day supply. Mail order 1 copay for 90 day supply</li> </ul>	<ul style="list-style-type: none"> <li>• \$10/\$35/\$70 for retail and mail order. Retail 1 copay for 30 day supply or 3 copay for 90 day supply. Mail order 1 copay for 90 day supply</li> </ul>
<b>Inpatient Hospital Benefits</b> <ul style="list-style-type: none"> <li>• Hospital benefits</li> <li>• Physician visits in the hospital</li> <li>• Inpatient physical rehabilitation</li> <li>• Surgery</li> <li>• Anesthesia</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 80%, subject to the deductible. Precertification applies.</li> <li>• Covered at 80%, subject to the deductible</li> <li>• Covered at 80%, subject to the deductible for up to 60 days per year. Precertification applies.</li> <li>• Covered at 80%, subject to the deductible or \$100 copay</li> <li>• Covered at 80%, subject to the deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full for unlimited days. Precertification applies.</li> <li>• Covered in full</li> <li>• Covered in full for up to 60 days per year</li> <li>• Covered in full</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• \$1000 copay subject to deductible.</li> <li>• \$25 copay subject to deductible.</li> <li>• \$1000 copay subject to deductible.</li> <li>• \$1000 copay subject to deductible.</li> <li>• Covered in full subject to deductible</li> </ul>
<b>Emergency Care</b> <ul style="list-style-type: none"> <li>• Emergency room care</li> <li>• Freestanding urgent care center</li> <li>• Ambulance</li> </ul>	<ul style="list-style-type: none"> <li>• \$50 copay per visit, unless admitted within 24 hours</li> <li>• \$25 copay per visit</li> <li>• \$50 copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$50 copay per visit, unless admitted within 24 hours</li> <li>• \$25 copay per visit</li> <li>• \$15 copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$150 copay per visit subject to deductible, unless admitted within 24 hours</li> <li>• \$40 copay subject to deductible</li> <li>• \$150 copay subject to deductible</li> </ul>
<b>Outpatient Hospital Benefits</b> <ul style="list-style-type: none"> <li>• Diagnostic x-rays</li> <li>• Diagnostic laboratory and pathology</li> <li>• Surgical care</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay per visit. Precertification applies to MRI, PET and CAT scans.</li> <li>• \$20 copay per visit</li> <li>• Covered at 80%, subject to the deductible</li> </ul>	<ul style="list-style-type: none"> <li>• \$15 copay per visit. Precertification applies to MRI, PET and CAT scans.</li> <li>• Covered in full</li> <li>• \$15 copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay subject to deductible</li> <li>• \$40 copay subject to deductible</li> <li>• \$100 copay subject to deductible</li> </ul>

<ul style="list-style-type: none"> <li>• Chemotherapy</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• \$25 copay subject to deductible</li> </ul>
type of care/plan features	Core Plan Coverage*	Enhanced Plan Coverage*	SimplyBlue Copay/Deductible Coverage*
<ul style="list-style-type: none"> <li>• Pulmonary Rehabilitation</li> <li>• Hemodialysis</li> <li>• Radiation therapy</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay per visit</li> <li>• Covered at 80%, subject to the deductible</li> <li>• \$40 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>• \$15 copay per visit</li> <li>• Covered in full</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay subject to deductible</li> <li>• \$40 copay subject to deductible</li> <li>• \$40 copay subject to deductible</li> </ul>
<b>Mental Health and Chemical Dependence</b>			
<ul style="list-style-type: none"> <li>• Inpatient mental health care</li> <li>• Outpatient mental health care</li> <li>• Inpatient chemical dependence</li> <li>• Outpatient chemical dependence</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 80%, subject to the deductible. Precertification applies.</li> <li>• \$40 copay. Services can be provided in an outpatient facility or in a provider office.</li> <li>• Covered at 80%, subject to the deductible. Precertification applies.</li> <li>• \$40 copay</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full for unlimited days. Precertification applies.</li> <li>• \$15 copay. Services can be provided in an outpatient facility or in a provider office.</li> <li>• Covered in full for unlimited days. Precertification applies.</li> <li>• \$15 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>• \$1000 copay subject to deductible.</li> <li>• \$40 copay subject to deductible</li> <li>• Covered in full for unlimited days. Precertification applies.</li> <li>• \$15 copay per visit</li> </ul>
<b>Other Services</b>			
<ul style="list-style-type: none"> <li>• Diabetic insulin and supplies</li> <li>• Skilled nursing facility</li> <li>• Home Care</li> <li>• Hospice</li> <li>• Outpatient therapy</li> <li>• Durable medical equipment and supplies</li> <li>• External prosthetics and orthotics</li> <li>• Chiropractic</li> <li>• Acupuncture</li> <li>• Dental</li> <li>• Hearing</li> <li>• Private Duty Nursing</li> <li>• Pre-admission testing</li> </ul>	<ul style="list-style-type: none"> <li>• \$20 copay for up to a 30 day supply</li> <li>• Covered at 80%, subject to the deductible for up to 120 days per year, 360 day lifetime max. Precertification applies.</li> <li>• \$20 per day, 40 visits per year. Precertification applies.</li> <li>• Covered in full for unlimited days.</li> <li>• \$40 copay per visit for a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy</li> <li>• Covered at 50%. Precertification applies.</li> <li>• Covered at 50%, subject to the deductible</li> <li>• \$20 copay per visit</li> <li>• Covered at 50% for up to 10 visits per year</li> <li>• Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly</li> <li>• \$20 copay for diagnostic exam, no coverage for routine exams. Hearing Aids covered up to \$2,000 per year</li> <li>• Not Covered</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• \$15 Copay</li> <li>• Covered in full for up to 120 days per year, 360 day lifetime max. Precertification applies.</li> <li>• Covered in full for unlimited visits. Precertification applies.</li> <li>• Covered in full for unlimited days</li> <li>• \$15 copay for up to a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy</li> <li>• Covered at 80%. Precertification applies.</li> <li>• Covered at 80%</li> <li>• \$15 copay per visit</li> <li>• Covered at 50% for up to 10 visits per year</li> <li>• Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly</li> <li>• \$15 copay for diagnostic exam, no coverage for routine exams. Hearing Aids covered up to \$2,000 per year</li> <li>• Not Covered</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• \$25 copay subject to deductible</li> <li>• \$1000 copay subject to deductible.</li> <li>• \$25 copay subject to deductible</li> <li>• 0% coinsurance subject to deductible</li> <li>• \$40 copay subject to deductible for up to a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy</li> <li>• Covered at 80% after deductible. Precertification applies.</li> <li>• Covered at 80%</li> <li>• \$25 copay subject to deductible</li> <li>• Not Covered</li> <li>• Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly</li> <li>• \$40 copay for diagnostic exam, no coverage for routine exams. Hearing Aids not covered.</li> <li>• Not Covered</li> <li>• Covered in full</li> </ul>