Benefit Category	When you stay IN-NETWORK Medicare Blue Choice® Value (HMO)	Medicare Blue Choice® Value Plus (HMO)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	Medicare Blue® PPO Plan 201 (PPO)	When you go OUT-OF-NETWORK Medicare Blue® PPO Plan 201 (PP
Premium	$20[1]	$74[1]	$137[1]	$96[1]	$74[1]	See "in-network" for prem
Annual Deductible	$0	$0	$0	$0	$0	$0
Prescription (Rx) Part D Benefit	No Deductible $6/$40/$90/33% Gap Coverage =86% for generics[2]	No Deductible $6/$40/$90/33% Gap Coverage =86% for generics[2]	No Deductible $6/$40/$90/33% Gap Coverage =86% for generics[2]	Not covered	No Deductible $6/$40/$90/33% Gap Coverage =86% for generics[2]	Emergency Only
Prescription Part B Benefit	20%	20%	20%	20%	20%	30%
Primary Care Physician (PCP)	$20/visit	$20/visit	$15/visit	$15/visit	$20/visit	$25/visit
Specialist	$40/visit	$40/visit	$35/visit	$35/visit	$40/visit	$45/visit
Preventive Health	$0	$0	$0	$0	$0	$0
Silver&Fit®	$10 annual fee $25 annual fee $150 annual allowance	$10 annual fee $25 annual fee $150 annual allowance	$10 annual fee $25 annual fee $150 annual allowance	$10 annual fee $25 annual fee $150 annual allowance	$10 annual fee $25 annual fee $150 annual allowance	$10 annual fee $25 annual fee $150 annual allowance
Outpatient Hospital Services* Subject to add. provider co-pay	$150/visit	$125/visit	$75/visit	$75/visit	$150/visit	30% coinsurance
ER Coverage (U.S. and Worldwide)** Co-pay waived if admitted w/i 23 hrs.	$65/visit	$65/visit	$65/visit	$65/visit	$65/visit	$65/visit
Inpatient Hospital Services*** (unlimited per benefit period) Subject to Medicare covered stay	Days 1-7 = $150/per day Day 8+ = fully covered	Stays 1-3 = $375/stay Stays 4+ = fully covered	Stays 1-3 = $275/stay Stays 4+ = fully covered	Stays 1-3 = $200/stay Stays 4+ = fully covered	Days 1-7 = $150/per day Day 8+= fully covered	30% coinsurance
Lab Services	$0	$0	$0	$0	$0	30% coinsurance
X-Ray & Radiology Services	20% coinsurance	10% coinsurance	10% coinsurance	10% coinsurance	20% coinsurance	30% coinsurance
Preventive Dental	Not covered	$0 copay for up to 2 oral exams, 2 cleanings and 2 dental x-rays per year	$0 copay for up to 2 oral exams, 2 cleanings and 2 dental x-rays per year	Not covered	Not covered	Not covered
Out-of-Pocket Maximum	$3,400 annually	$3,400 annually	$3,400 annually	$3,400 annually	$4,000 annually	$10,000 (combined in-and out-of-network)