



Blue Balance FundedSM
The Level-Funded Solution

Jan. 1 through Dec. 31, 2026

Blue Cross and Blue Shield of Illinois offers Blue Balance Funded, an administrative and stop loss coverage suite of services that includes consistent monthly payments for employers.

Blue Balance Funded features:

New in 2026:

Expanded Availability and Enhancements

- Blue Balance Funded is now available to employers with as few as 5 enrolled employees, making the offering available to employers with 5 - 150 enrolled employees.
- Enhancements to the Blue Balance Funded product include:
 - Extension of the stop loss run out period to 60 months
 - A streamlined renewal process
 - An improved paperwork process for enrollment and renewals.

Predictable Monthly Payments¹

Blue Balance Funded's monthly invoice includes the employer cost for claims funding, administrative fees and stop loss premiums. For added convenience, BCBSIL manages all three with an online billing system available through Blue Access for EmployersSM.

Stop Loss Coverage

Stop loss insurance provides protection for covered claims costs resulting from individual and aggregate claims exceeding the predetermined stop loss levels.

Possible Credit

After the annual settlement, if the actual claims cost is less than the claims funding, groups will be eligible for a credit toward future monthly payments.

Women's and Family Health in collaboration with Maven

Meet Maven, your digital maternity program! Members get personalized 24/7 virtual support, care and guidance for pregnancy, postpartum and newborn care with Maven. Members can meet with providers anytime, day or night, so they can get the care they need, when they need it.

In addition to Maven Maternity, BCBSIL is here to support, educate and share information regarding high-risk conditions, such as gestational diabetes and preeclampsia.

Together, BCBSIL and Maven, will get members the care they need for their pregnancy and postpartum journey.

Blue Balance Funded provides a wide array of services and resources including:

- Includes groups with up to 150 employees
- Claims adjudication
- Customer service for members
- Access to a network of contracting health care providers
- Pharmacy benefit management
- Virtual Visits by MDLIVE[®]
- Wondr online, digital weight management program that teaches members science-based skills that help them lose weight, sleep better, manage stress and more
- The **BlueCard[®]** program, which provides access to a nationwide network of providers
- Wellbeing Management integrated medical and behavioral health management programs
- **Well onTarget[®]** wellness tools and resources (including health assessments, self-directed courses and a rewards program that reinforces positive lifestyle changes) to help promote good health
- Blue InsightSM reporting, an online analysis and reporting system which allows employers to identify claims costs and utilization trends using a wide variety of standard reports and profiles, providing opportunities to manage your benefits
- Employee Assistance Program, through which members have access to clinical therapy sessions; family, legal and financial counseling; and online guidance resources
- Airrosti Flex is a solution for members seeking evidence-based, minimally invasive treatment for acute musculoskeletal pain in the comfort of their home with health coaches and self-directed care plans. This solution aims to improve care pathway for MSK pain, reduce spend on unnecessary surgery and provide nation-wide access for members needing this type of care (myofascial release).



The decision to self-insure is an important one and involves certain responsibilities on the employer's part.

To learn if Blue Balance Funded might be right for your groups, talk with your BCBSIL sales executive or account manager. Groups should also consult with their legal and tax advisers.

1. The amount of the monthly payment may fluctuate depending on the number of enrolled employees. It is recalculated each year and is subject to change. Employers are solely responsible for taxes, fees, and obtaining and paying for their own accounting and legal services.

Blue Balance Funded--Effective Jan. 1, 2026. Plans are subject to change. Available to ACA-defined small employer groups.*

Plan ID	Plan Name	HSA Y/N	Coins Plan	Indiv Ded	Fam Ded	Indiv OPX	Fam OPX	Primary Care Office Visits Copay	Specialist Visit Copay	ER Facility			Urgent Visit Copay	Preferred Drug Plan
										Cost	Per Occurrence Deductible/Copay	Share		
BluePrint PPO														
AIBPP615	BluePrint PPO A615 - Rx Copays	No	80%	\$750	\$2,250	\$3,000	\$9,000	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
AIBPP617	BluePrint PPO A617 - Rx Copays	No	80%	\$1,250	\$3,750	\$3,500	\$10,500	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
AIBPP618	BluePrint PPO A618 - Rx Copays	No	80%	\$2,500	\$7,500	\$5,000	\$15,000	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
AIBPP619	BluePrint PPO A619 - Rx Copays	No	80%	\$3,500	\$10,500	\$6,000	\$12,000	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
AIBPP620	BluePrint PPO A620 - Rx Copays	No	80%	\$5,000	\$12,000	\$6,100	\$12,200	\$45	\$70	\$250	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
Blue Choice OptionsSM														
AIBCO609	Blue Choice Options A609 - Rx Copays	No	90% / 70%	\$750 / \$1,750	\$2,250 / \$5,250	\$4,500 / \$6,100	\$9,000 / \$12,200	\$25 / \$55	\$50 / \$110	\$400	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
AIBCO610	Blue Choice Options A610 - Rx Copays	No	90% / 70%	\$1,500 / \$3,750	\$4,500 / \$11,250	\$3,500 / \$6,000	\$10,500 / \$12,000	\$35 / \$55	\$60 / \$110	\$400	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
AICOE691	Blue Choice Options AE691	Yes - Embedded ²	100% / 80%	\$3,500 / \$4,600	\$10,500 / \$13,800	\$3,500 / \$6,550	\$10,500 / \$14,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	100%
AICOE492	Blue Choice Options AE492	Yes - Embedded ²	100% / 80%	\$4,000 / \$5,700	\$12,000 / \$14,800	\$4,000 / \$7,500	\$12,000 / \$15,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	100%
AICOE493	Blue Choice Options AE493	Yes - Embedded ²	80% / 60%	\$5,000 / \$6,000	\$10,000 / \$12,000	\$6,000 / \$7,000	\$12,000 / \$14,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	90%/90%/80%/70%/60%/50%
Blue Choice Select PPOSM														
AIBCS617	Blue Choice Select PPO A617 - Rx Copays	No	80%	\$1,250	\$3,750	\$3,500	\$10,500	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
AIBCS616	Blue Choice Select PPO A616 - Rx Copays	No	80%	\$1,500	\$4,500	\$4,000	\$12,000	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
AIBCS618	Blue Choice Select PPO A618 - Rx Copays	No	80%	\$2,500	\$7,500	\$5,000	\$15,000	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350

*Requires a minimum of 5 enrolled.

Notes:

Coins = Coinsurance. OV = Office Visit. SPC OV = Specialist Office Visit. OPX = Out-of-Pocket Maximum. DC = Deductible and Coinsurance. POD = Per Occurrence Deductible.

1. Aggregate Health Saving Account (HSA) plan. Family membership must meet the family deductible and out-of-pocket amounts.

2. Embedded Health Savings (HSA) plan. Once an individual within the family has met the Individual deductible, that particular member will be eligible for benefits.

All HSA plans include the HDHP-HSA preventive prescription drugs will be covered with no member cost share. Please see myprime.com for more information.

These columns refer to in-network benefits only. Members will pay more if they receive services out of network. Please refer to your benefit booklet for more details.

Blue Balance Funded--Effective Jan. 1, 2026. Plans are subject to change. Available to ACA-defined small employer groups.*

Plan ID	Plan Name	HSA Y/N	Coins Plan	Indiv Ded	Fam Ded	Indiv OPX	Fam OPX	Primary Care Office Visits Copay	Specialist Visit Copay	ER Facility			Urgent Visit Copay	Preferred Drug Plan
										Cost	Per Occurrence Deductible/Copay	Share		
BlueEdge HSASM														
AIEEA291	BlueEdge HSA AA291	Yes - Aggregate ¹	100%	\$2,500	\$5,000	\$5,000	\$7,350	DC	DC	NA	NA	DC	DC	100%
AIEEE691	BlueEdge HSA AE691	Yes - Embedded ²	100%	\$3,500	\$7,000	\$3,500	\$7,000	DC	DC	NA	NA	DC	DC	100%
AIEEE692	BlueEdge HSA AE692	Yes - Embedded ²	80%	\$3,500	\$7,000	\$7,000	\$14,000	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
AIEEE493	BlueEdge HSA AE493	Yes - Embedded ²	100%	\$6,000	\$12,000	\$6,000	\$12,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge Select HSASM														
AIESA491	BlueEdge Select HSA AA491	Yes - Aggregate ¹	80%	\$2,500	\$5,000	\$5,000	\$7,350	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%

*Requires a minimum of 5 enrolled.

Notes:

Coins = Coinsurance. OV = Office Visit. SPC OV = Specialist Office Visit. OPX = Out-of-Pocket Maximum. DC = Deductible and Coinsurance. POD = Per Occurrence Deductible.

1. Aggregate Health Saving Account (HSA) plan. Family membership must meet the family deductible and out-of-pocket amounts.

2. Embedded Health Savings (HSA) plan. Once an individual within the family has met the Individual deductible, that particular member will be eligible for benefits.

All HSA plans include the HDHP-HSA preventive prescription drugs will be covered with no member cost share. Please see myprime.com for more information.

These columns refer to in-network benefits only. Members will pay more if they receive services out of network. Please refer to your benefit booklet for more details.

Blue Balanced Funded - Effective as of January 1, 2026. Plans are subject to change. All plans are available to Mid-Market Employer Groups*.

										ER Facility				
Plan Name	Plan ID	HSA Y/N	Coins Plan	Individual Deductible	Family Deductible	Individual OPX	Family OPX	Primary Care Office Visits	Specialist Office Visits	Cost	Per Occurrence Deductible/ Copay	Share	Urgent Visit Copay	Preferred Drug Plan
Blueprint PPO														
BluePrint PPO A501 - Rx Copays	AIBPP501M	No	90%	\$0	\$0	\$1,000	\$3,000	\$20	\$40	\$150	Copay	100%	DC	\$0/\$10/\$50/\$100/\$150/\$250
BluePrint PPO A621 - Rx Copays	AIBPP621M	No	80%	\$250	\$750	\$1,250	\$3,750	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
BluePrint PPO A602 - Rx Copays	AIBPP602M	No	80%	\$500	\$1,500	\$1,750	\$5,250	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
BluePrint PPO A603 - Rx Copays	AIBPP603M	No	90%	\$750	\$2,250	\$2,000	\$6,000	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A615 - Rx Copays	AIBPP615	No	80%	\$750	\$2,250	\$3,000	\$9,000	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A604 - Rx Copays	AIBPP604M	No	80%	\$750	\$2,250	\$6,500	\$18,400	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A605 - Rx Copays	AIBPP605M	No	90%	\$1,000	\$3,000	\$2,500	\$7,500	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A617 - Rx Copays	AIBPP617	No	80%	\$1,250	\$3,750	\$3,500	\$10,500	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A606 - Rx Copays	AIBPP606M	No	80%	\$1,250	\$3,750	\$4,500	\$13,500	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A616 - Rx Copays	AIBPP616M	No	80%	\$1,500	\$4,500	\$4,000	\$12,000	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A607 - Rx Copays	AIBPP607M	No	80%	\$2,000	\$6,000	\$5,000	\$15,000	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
BluePrint PPO A608 - Rx Copays	AIBPP608M	No	80%	\$2,250	\$6,750	\$4,500	\$13,500	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
BluePrint PPO A609 - Rx Copays	AIBPP609M	No	80%	\$2,250	\$6,750	\$6,500	\$18,000	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350

*Available to employers with over 50 total employees.

Notes:

Coins = Coinsurance. OV = Office Visit. SPC OV = Specialist Office Visit. OPX = Out-of-Pocket Maximum. DC = Deductible and Coinsurance. POD = Per Occurrence Deductible.

1. Aggregate Health Saving Account (HSA) plan. Family membership must meet the family deductible and out-of-pocket amounts.

2. Embedded Health Savings (HSA) plan. Once an individual within the family has met the Individual deductible, that particular member will be eligible for benefits.

All HSA plans include the HDHP-HSA preventive prescription drugs will be covered with no member cost share. Please see myprime.com for more information.

These columns refer to in-network benefits only. Members will pay more if they receive services out of network. Please refer to your benefit booklet for more details.

Blue Balanced Funded - Effective as of January 1, 2026. Plans are subject to change. All plans are available to Mid-Market Employer Groups*.

Plan Name	Plan ID	HSA Y/N	Coins Plan	Individual Deductible	Family Deductible	Individual OPX	Family OPX	Primary Care Office Visits	Specialist Office Visits	ER Facility			Urgent Visit Copay	Preferred Drug Plan
										Cost	Per Occurrence Deductible/ Copay	Share		
BluePrint PPO														
BluePrint PPO A618 - Rx Copays	AIBPP618	No	80%	\$2,500	\$7,500	\$5,000	\$15,000	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A610 - Rx Copays	AIBPP610M	No	90%	\$2,750	\$8,250	\$4,000	\$12,000	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A611 - Rx Copays	AIBPP611M	No	80%	\$2,750	\$8,250	\$6,000	\$12,000	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A612 - Rx Copays	AIBPP612M	No	80%	\$3,000	\$9,000	\$6,500	\$18,400	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A619 - Rx Copays	AIBPP619	No	80%	\$3,500	\$10,500	\$6,000	\$12,000	\$25	\$50	\$150	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A613 - Rx Copays	AIBPP613M	No	80%	\$4,250	\$12,750	\$6,000	\$18,000	\$35	\$60	\$150	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
BluePrint PPO A620 - Rx Copays	AIBPP620	No	80%	\$5,000	\$12,000	\$6,100	\$12,200	\$45	\$70	\$250	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
BluePrint PPO A514 - Rx Copays	AIBPP514M	No	80%	\$5,000	\$12,000	\$8,550	\$17,100	\$40	\$60	\$250	Copay	100%	DC	\$0/\$10/\$50/\$100/\$150/\$250

*Available to employers with over 50 total employees.

Notes:

Coins = Coinsurance. OV = Office Visit. SPC OV = Specialist Office Visit. OPX = Out-of-Pocket Maximum. DC = Deductible and Coinsurance. POD = Per Occurrence Deductible.

1. Aggregate Health Saving Account (HSA) plan. Family membership must meet the family deductible and out-of-pocket amounts.

2. Embedded Health Savings (HSA) plan. Once an individual within the family has met the Individual deductible, that particular member will be eligible for benefits.

All HSA plans include the HDHP-HSA preventive prescription drugs will be covered with no member cost share. Please see myprime.com for more information.

These columns refer to in-network benefits only. Members will pay more if they receive services out of network. Please refer to your benefit booklet for more details.

Blue Balanced Funded - Effective as of January 1, 2026. Plans are subject to change. All plans are available to Mid-Market Employer Groups*.

										ER Facility				
Plan Name	Plan ID	HSA Y/N	Coins Plan	Individual Deductible	Family Deductible	Individual OPX	Family OPX	Primary Care Office Visits	Specialist Office Visits	Cost	Per Occurrence Deductible/ Copay	Share	Urgent Visit Copay	Preferred Drug Plan
Blue Choice Options														
Blue Choice Options A601 - Rx Copays	AIBCO601M	No	90% / 70%	\$500 / \$1,250	\$1,500 / \$3,750	\$1,250 / \$1,500	\$2,500 / \$4,500	\$25 / \$45	\$50 / \$90	\$400	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options A602 - Rx Copays	AIBCO602M	No	100% / 70%	\$750 / \$1,750	\$2,250 / \$5,250	\$750 / \$3,500	\$2,250 / \$10,500	\$25 / \$55	\$50 / \$110	\$400	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options A609 - Rx Copays	AIBCO609	No	90% / 70%	\$750 / \$1,750	\$2,250 / \$5,250	\$4,500 / \$6,100	\$9,000 / \$12,200	\$25 / \$55	\$50 / \$110	\$400	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options A603 - Rx Copays	AIBCO603M	No	90% / 70%	\$1,000 / \$2,500	\$3,000 / \$7,500	\$3,000 / \$6,000	\$9,000 / \$12,000	\$30 / \$55	\$60 / \$110	\$400	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options A610 - Rx Copays	AIBCO610	No	90% / 70%	\$1,500 / \$3,750	\$4,500 / \$11,250	\$3,500 / \$6,000	\$10,500 / \$12,000	\$35 / \$55	\$60 / \$110	\$400	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options A607 - Rx Copays	AIBCO607M	No	90% / 70%	\$2,000 / \$4,000	\$8,000 / \$16,000	\$4,500 / \$6,500	\$9,000 / \$18,000	\$35 / \$55	\$60 / \$110	\$400	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options A604 - Rx Copays	AIBCO604M	No	80% / 60%	\$2,500 / \$4,000	\$7,500 / \$12,000	\$5,000 / \$6,000	\$15,000 / \$18,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	\$5/\$15/\$60/\$110/\$250/\$350
Blue Choice Options A608 - Rx Copays	AIBCO608M	No	80% / 60%	\$3,000 / \$4,500	\$9,000 / \$18,000	\$5,500 / \$6,500	\$9,000 / \$18,000	\$40 / \$65	\$65 / \$130	\$500	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options A605 - Rx Copays	AIBCO605M	No	80% / 60%	\$4,250 / \$5,250	\$10,500 / \$10,500	\$6,100 / \$6,100	\$12,200 / \$12,200	\$40 / \$65	\$65 / \$130	\$500	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options A606 - Rx Copays	AIBCO606M	No	80% / 60%	\$5,250 / \$6,250	\$10,500 / \$12,500	\$7,100 / \$8,100	\$14,200 / \$16,200	\$45 / \$70	\$70 / \$130	\$500	POD	DC (Tier 1)	\$75	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Options AE691	AICOE691	Yes - Embedded ²	100% / 80%	\$3,500 / \$4,600	\$10,500 / \$13,800	\$3,500 / \$6,550	\$10,500 / \$14,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	100%
Blue Choice Options AE592	AICOE592M	Yes - Embedded ²	80% / 60%	\$3,500 / \$5,000	\$7,000 / \$10,000	\$5,500 / \$7,000	\$11,000 / \$14,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	90%/90%/80%/70%/60%/50%
Blue Choice Options AE492	AICOE492	Yes - Embedded ²	100% / 80%	\$4,000 / \$5,700	\$12,000 / \$14,800	\$4,000 / \$7,500	\$12,000 / \$15,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	100%
Blue Choice Options AE493	AICOE493	Yes - Embedded ²	80% / 60%	\$5,000 / \$6,000	\$10,000 / \$12,000	\$6,000 / \$7,000	\$12,000 / \$14,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	90%/90%/80%/70%/60%/50%
Blue Choice Options AE593	AICOE593M	Yes - Embedded ²	80% / 60%	\$6,000 / \$7,000	\$12,000 / \$14,000	\$7,000 / \$7,500	\$14,000 / \$15,000	DC / DC	DC / DC	NA	NA	DC (Tier 1)	DC	90%/90%/80%/70%/60%/50%

*Available to employers with over 50 total employees.

Notes:

Coins = Coinsurance. OV = Office Visit. SPC OV = Specialist Office Visit. OPX = Out-of-Pocket Maximum. DC = Deductible and Coinsurance. POD = Per Occurrence Deductible.

1. Aggregate Health Saving Account (HSA) plan. Family membership must meet the family deductible and out-of-pocket amounts.

2. Embedded Health Savings (HSA) plan. Once an individual within the family has met the Individual deductible, that particular member will be eligible for benefits.

All HSA plans include the HDHP-HSA preventive prescription drugs will be covered with no member cost share. Please see myprime.com for more information.

These columns refer to in-network benefits only. Members will pay more if they receive services out of network. Please refer to your benefit booklet for more details.

Blue Balanced Funded - Effective as of January 1, 2026. Plans are subject to change. All plans are available to Mid-Market Employer Groups*.

										ER Facility				
Plan Name	Plan ID	HSA Y/N	Coins Plan	Individual Deductible	Family Deductible	Individual OPX	Family OPX	Primary Care Office Visits	Specialist Office Visits	Cost	Per Occurrence Deductible/ Copay	Share	Urgent Visit Copay	Preferred Drug Plan
Blue Choice Select PPO														
Blue Choice Select PPO A621 - Rx Copays	AIBCS621M	No	80%	\$250	\$750	\$1,250	\$3,750	\$25	\$25	\$150	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A602 - Rx Copays	AIBCS602M	No	80%	\$500	\$1,500	\$1,750	\$5,250	\$25	\$25	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A603 - Rx Copays	AIBCS603M	No	90%	\$750	\$2,250	\$2,000	\$6,000	\$25	\$25	\$200	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
Blue Choice Select PPO A615 - Rx Copays	AIBCS615M	No	80%	\$750	\$2,250	\$3,000	\$9,000	\$25	\$25	\$200	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
Blue Choice Select PPO A605 - Rx Copays	AIBCS605M	No	90%	\$1,000	\$3,000	\$2,500	\$7,500	\$25	\$25	\$200	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
Blue Choice Select PPO A617 - Rx Copays	AIBCS617	No	80%	\$1,250	\$3,750	\$3,500	\$10,500	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A616 - Rx Copays	AIBCS616	No	80%	\$1,500	\$4,500	\$4,000	\$12,000	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A607 - Rx Copays	AIBCS607M	No	80%	\$2,000	\$6,000	\$5,000	\$15,000	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A608 - Rx Copays	AIBCS608M	No	80%	\$2,250	\$6,750	\$4,500	\$13,500	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A618 - Rx Copays	AIBCS618	No	80%	\$2,500	\$7,500	\$5,000	\$15,000	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
Blue Choice Select PPO A612 - Rx Copays	AIBCS612M	No	80%	\$3,000	\$9,000	\$6,500	\$18,400	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$60/\$110/\$250/\$350
Blue Choice Select PPO A619 - Rx Copays	AIBCS619M	No	80%	\$3,500	\$10,500	\$6,000	\$12,000	\$25	\$25	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A613 - Rx Copays	AIBCS613M	No	80%	\$4,250	\$12,750	\$6,000	\$18,000	\$35	\$35	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A620 - Rx Copays	AIBCS620M	No	80%	\$5,000	\$12,000	\$6,100	\$12,200	\$45	\$45	\$200	Copay	100%	DC	\$5/\$15/\$45/\$85/\$250/\$350
Blue Choice Select PPO A514 - Rx Copays	AIBCS514M	No	80%	\$5,000	\$12,000	\$8,550	\$17,100	\$40	\$60	\$200	Copay	100%	DC	\$0/\$10/\$35/\$75/\$150/\$250

*Available to employers with over 50 total employees.

Notes:

Coins = Coinsurance. OV = Office Visit. SPC OV = Specialist Office Visit. OPX = Out-of-Pocket Maximum. DC = Deductible and Coinsurance. POD = Per Occurrence Deductible.

1. Aggregate Health Saving Account (HSA) plan. Family membership must meet the family deductible and out-of-pocket amounts.

2. Embedded Health Savings (HSA) plan. Once an individual within the family has met the Individual deductible, that particular member will be eligible for benefits.

All HSA plans include the HDHP-HSA preventive prescription drugs will be covered with no member cost share. Please see myprime.com for more information.

These columns refer to in-network benefits only. Members will pay more if they receive services out of network. Please refer to your benefit booklet for more details.

Blue Balanced Funded - Effective as of January 1, 2026. Plans are subject to change. All plans are available to Mid-Market Employer Groups*.

										ER Facility				
Plan Name	Plan ID	HSA Y/N	Coins Plan	Individual Deductible	Family Deductible	Individual OPX	Family OPX	Primary Care Office Visits	Specialist Office Visits	Cost	Per Occurrence Deductible/ Copay	Share	Urgent Visit Copay	Preferred Drug Plan
BlueEdge HSA														
BlueEdge HSA AA691	AIEEA691M	Yes - Aggregate ¹	100%	\$1,800	\$3,600	\$3,600	\$7,200	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge HSA AA692	AIEEA692M	Yes - Aggregate ¹	80%	\$1,800	\$3,600	\$3,600	\$7,200	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge HSA AA291	AIEEA291	Yes - Aggregate ¹	100%	\$2,500	\$5,000	\$5,000	\$7,350	DC	DC	NA	NA	DC	DC	100%
BlueEdge HSA AA593	AIEEA593M	Yes - Aggregate ¹	80%	\$2,500	\$5,000	\$5,000	\$7,350	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge HSA AE691	AIEEE691	Yes - Embedded ²	100%	\$3,500	\$7,000	\$3,500	\$7,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge HSA AA594	AIEEA594M	Yes - Aggregate ¹	80%	\$3,500	\$7,000	\$5,800	\$7,350	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge HSA AE692	AIEEE692	Yes - Embedded ²	80%	\$3,500	\$7,000	\$7,000	\$14,000	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge HSA AE594	AIEEE594M	Yes - Embedded ²	100%	\$4,000	\$8,000	\$4,000	\$8,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge HSA AE596	AIEEE596M	Yes - Embedded ²	100%	\$5,000	\$10,000	\$5,000	\$10,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge HSA AE595	AIEEE595M	Yes - Embedded ²	80%	\$5,000	\$10,000	\$7,000	\$14,000	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge HSA AE493	AIEEE493	Yes - Embedded ²	100%	\$6,000	\$12,000	\$6,000	\$12,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge HSA AE597	AIEEE597M	Yes - Embedded ²	100%	\$7,500	\$15,000	\$7,500	\$15,000	DC	DC	NA	NA	DC	DC	100%

*Available to employers with over 50 total employees.

Notes:

Coins = Coinsurance. OV = Office Visit. SPC OV = Specialist Office Visit. OPX = Out-of-Pocket Maximum. DC = Deductible and Coinsurance. POD = Per Occurrence Deductible.

1. Aggregate Health Saving Account (HSA) plan. Family membership must meet the family deductible and out-of-pocket amounts.

2. Embedded Health Savings (HSA) plan. Once an individual within the family has met the Individual deductible, that particular member will be eligible for benefits.

All HSA plans include the HDHP-HSA preventive prescription drugs will be covered with no member cost share. Please see myprime.com for more information.

These columns refer to in-network benefits only. Members will pay more if they receive services out of network. Please refer to your benefit booklet for more details.

Blue Balanced Funded - Effective as of January 1, 2026. Plans are subject to change. All plans are available to Mid-Market Employer Groups*.

										ER Facility				
Plan Name	Plan ID	HSA Y/N	Coins Plan	Individual Deductible	Family Deductible	Individual OPX	Family OPX	Primary Care Office Visits	Specialist Office Visits	Cost	Per Occurrence Deductible/ Copay	Share	Urgent Visit Copay	Preferred Drug Plan
BlueEdge Select HSA														
BlueEdge Select HSA AA593	AIESA593M	Yes - Aggregate ¹	100%	\$2,500	\$5,000	\$2,500	\$5,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge Select HSA AA491	AIESA491	Yes - Aggregate ¹	80%	\$2,500	\$5,000	\$5,000	\$7,350	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge Select HSA AE598	AIEESE98M	Yes - Embedded ²	80%	\$3,500	\$7,000	\$7,000	\$14,000	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge Select HSA AE594	AIEESE94M	Yes - Embedded ²	100%	\$4,000	\$8,000	\$4,000	\$8,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge Select HSA AE596	AIEESE96M	Yes - Embedded ²	100%	\$5,000	\$10,000	\$5,000	\$10,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge Select HSA AE595	AIEESE95M	Yes - Embedded ²	80%	\$5,000	\$10,000	\$7,000	\$14,000	DC	DC	NA	NA	DC	DC	90%/90%/80%/70%/60%/50%
BlueEdge Select HSA AA599	AIEESE99M	Yes - Embedded ²	100%	\$6,000	\$12,000	\$6,000	\$12,000	DC	DC	NA	NA	DC	DC	100%
BlueEdge Select HSA AE597	AIEESE97M	Yes - Embedded ²	100%	\$7,500	\$15,000	\$7,500	\$15,000	DC	DC	NA	NA	DC	DC	100%

*Available to employers with over 50 total employees.

Notes:

Coins = Coinsurance. OV = Office Visit. SPC OV = Specialist Office Visit. OPX = Out-of-Pocket Maximum. DC = Deductible and Coinsurance. POD = Per Occurrence Deductible.

1. Aggregate Health Saving Account (HSA) plan. Family membership must meet the family deductible and out-of-pocket amounts.

2. Embedded Health Savings (HSA) plan. Once an individual within the family has met the Individual deductible, that particular member will be eligible for benefits.

All HSA plans include the HDHP-HSA preventive prescription drugs will be covered with no member cost share. Please see myprime.com for more information.

These columns refer to in-network benefits only. Members will pay more if they receive services out of network. Please refer to your benefit booklet for more details.

Blue Balance Funded--Effective Jan. 1, 2026. Plans are subject to change. Available to ACA-defined small employer groups.

PPO Dental Plans

Plan ID	Plan Name	Segment	Coinsurance - In Network				Coinsurance - Out of Network				Plan Type	Allocation	Deductible Waved ²	Annual Maximum	Ortho Lifetime Maximum	Deductible INN/OON (3x Family Limit)	OON Reimbursement	Implants ⁶	Waiting Periods
			Class I	Class II	Class III	Class IV	Class I	Class II	Class III	Class IV									
DILHR30	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	High	Yes	\$5,000	\$2,000	\$25/\$25	90th R&C	Yes	No
DILHR31	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	High	Yes	\$3,000	\$2,000	\$25/\$25	90th R&C	Yes	No
DILHR32	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	High	Yes	\$2,000	\$2,000	\$50/\$50	90th R&C	Yes	No
DILHR33	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	High	Yes	\$1,500	\$1,500	\$50/\$50	90th R&C	Yes	No
DILHR34	PPO Dental	Contributory	100%	80%	50%	50%	80%	60%	50%	50%	Active	High	Yes	\$1500/\$1000	\$1,000	\$50/\$75	90th R&C	Yes	No
DILHR35	PPO Dental	Contributory	100%	90%	60%	50%	100%	80%	50%	50%	Active	High	Yes	\$2,000	\$2,000	\$0/\$0	90th R&C	Yes	No
DILLR36	PPO Dental	Contributory	100%	80%	50%	N/A	100%	80%	50%	N/A	Passive	Low	Yes	\$1,000	N/A	\$50/\$50	90th R&C	No	No
DILHM38	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	High	Yes	\$1,000	\$1,000	\$50/\$50	MAC	No	No
DILHM40	PPO Dental	Contributory	100%	80%	50%	N/A	80%	60%	40%	N/A	Active	High	Yes	\$1500/\$1000	N/A	\$50/\$50	MAC	No	No
DILLM41	PPO Dental	Contributory	90%	70%	50%	N/A	70%	50%	30%	N/A	Active	Low	Yes	\$1,000	N/A	\$75/\$75	MAC	No	No
DILHM42	PPO Dental	Contributory	100%	80% ⁴	N/A	N/A	100%	80% ⁴	N/A	N/A	Passive	High	Yes	\$750	N/A	\$25/\$75	MAC	No	No
DILHR50	PPO Dental	Contributory	100%	80%	50%	N/A	100%	80%	50%	N/A	Passive	High	Yes	\$1,500	N/A	\$50/\$50	90th R&C	No	No
DILLM51	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	Low	Yes	\$1,000	\$1,000	\$50/\$50	MAC	No	No
DILHM57	PPO Dental	Contributory	100%	100%	60%	50%	100%	100%	60%	50%	Passive	High	Yes	\$1,500	\$1,500	\$50/\$50	MAC	Yes	No
DILLR58 ⁵	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	Low	Yes	\$1,000	\$1,000	\$50/\$50	90th R&C	No	No
DILHR61	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	High	Yes	\$2,000	\$1,000	\$50/\$50	90th R&C	No	No

	High Allocation Coinsurance ¹	Low Allocation Coinsurance ¹	Waiting Period ³
Diag Evaluations	Class I	Class I	
Preventive	Class I	Class I	
Diag Radiographs	Class I	Class I	
Misc Prev Services	Class I	Class II	
Basic Restorative	Class II	Class II	
Non-Surg Extractions	Class II	Class II	
Non-Surg Perio	Class II	Class II	
Adjunctive Services	Class II	Class II	
Endodontics	Class II	Class III	
Oral Surgery	Class II	Class III	
Surgical Perio	Class II	Class III	12 month
Major Restorative	Class III	Class III	12 month
Prosthodontics	Class III	Class III	12 month
Misc Rest & Prosth Services	Class III	Class III	12 month
Orthodontics (Adult & Child coverage)	Class IV	Class IV	N/A

2. Waived Deductible applies to all Class I services and Class IV Orthodontic services
4. Only Basic Restorative Services are covered.
5. Prev/Diag services do not count toward annual max.
6. Implants are covered at the same percentage as prosthodontics.

Plan Pairings (Groups 10+)

Any one contributory high option can be paired with any one contributory low option.
 Any one voluntary high option can be paired with any one voluntary low option.
 Voluntary plans and contributory plans may not be offered together.
 Exception: DILHM57, DOKHM57 & DNMHM57 can be paired with DILHR33, DOKHR33 and DNMHR33.
 Also: DILHM59, DOKHM59 & DNMHM59 can be paired with DILHR43, DOKHR43 & DNMHR43 respectively
 Also DILHM42, DOKHM42 & DNMHM42 can be paired with any contributory plan.
 And DILHM46, DOKHM46 & DNMHM46 can be paired with any voluntary plan

Participation Requirements for IL

Contributory	Voluntary
>70% participation	>25% participation
>50% employer contribution	<50% employer contribution

Blue Balance Funded--Effective Jan. 1, 2026. Plans are subject to change. Available to ACA-defined small employer groups.*

PPO Dental Plans

Plan ID	Plan Name	Segment	Coinsurance - In Network				Coinsurance - Out of Network				Plan Type	Allocation	Deductible Waved ²	Annual Maximum	Ortho Lifetime Maximum	Deductible INN/OON (3x Family Limit)	OON Reimbursement	Implants ⁶	Waiting Periods
			Class I	Class II	Class III	Class IV	Class I	Class II	Class III	Class IV									
DILLR62	PPO Dental	Contributory	100%	80%	50%	50%	100%	80%	50%	50%	Passive	Low	Yes	\$1,500	\$1,000	\$50/\$50	90th R&C	No	No
DILHR43	PPO Dental	Voluntary	100%	80%	50%	50%	100%	80%	50%	50%	Passive	High	Yes	\$1,500	\$1,500	\$50/\$50	90th R&C	No	Yes
DILHM44	PPO Dental	Voluntary	100%	80%	50%	N/A	80%	60%	40%	N/A	Active	High	Yes	\$1500/\$1000	N/A	\$50/\$50	MAC	No	Yes
DILHR45	PPO Dental	Voluntary	100%	90%	60%	50%	100%	80%	50%	50%	Active	High	Yes	\$2,000	\$2,000	\$25/\$75	90th R&C	No	Yes
DILHM46	PPO Dental	Voluntary	100%	80% ⁴	N/A	N/A	100%	80% ⁴	N/A	N/A	Passive	High	Yes	\$750	N/A	\$25/\$75	MAC	No	No
DILLR47	PPO Dental	Voluntary	100%	80%	50%	N/A	100%	80%	50%	N/A	Passive	Low	Yes	\$1,500	N/A	\$50/\$50	90th R&C	No	Yes
DILLR48	PPO Dental	Voluntary	100%	80%	50%	50%	100%	80%	50%	50%	Passive	Low	Yes	\$1,500	\$1,000	\$50/\$50	90th R&C	No	Yes
DILLM49	PPO Dental	Voluntary	100%	80%	50%	NA	100%	80%	50%	NA	Passive	Low	Yes	\$1,000	NA	\$50/\$50	MAC	No	Yes
DILHR53	PPO Dental	Voluntary	100%	80%	50%	N/A	100%	80%	50%	N/A	Passive	High	Yes	\$1,500	N/A	\$50/\$50	90th R&C	No	Yes
DILLR54	PPO Dental	Voluntary	100%	80%	50%	N/A	100%	80%	50%	N/A	Passive	Low	Yes	\$1,000	N/A	\$50/\$50	90th R&C	No	Yes
DILLM55	PPO Dental	Voluntary	100%	80%	50%	50%	100%	80%	50%	50%	Passive	Low	Yes	\$1,000	\$1,000	\$50/\$50	MAC	No	Yes
DILLM56	PPO Dental	Voluntary	100%	80%	50%	N/A	100%	50%	50%	N/A	Active	Low	Yes	\$750	N/A	\$50/\$100	MAC	No	Yes
DILHM59	PPO Dental	Voluntary	100%	100%	60%	50%	100%	100%	60%	50%	Passive	High	Yes	\$1,500	\$1,500	\$50/\$50	MAC	No	Yes
DILLR60 ⁵	PPO Dental	Voluntary	100%	80%	50%	50%	100%	80%	50%	50%	Passive	Low	Yes	\$1,000	\$1,000	\$50/\$50	90th R&C	No	Yes

	High Allocation Coinsurance ¹	Low Allocation Coinsurance ¹	Waiting Period ³
Diag Evaluations	Class I	Class I	
Preventive	Class I	Class I	
Diag Radiographs	Class I	Class I	
Misc Prev Services	Class I	Class II	
Basic Restorative	Class II	Class II	
Non-Surg Extractions	Class II	Class II	
Non-Surg Perio	Class II	Class II	
Adjunctive Services	Class II	Class II	
Endodontics	Class II	Class III	
Oral Surgery	Class II	Class III	
Surgical Perio	Class II	Class III	12 month
Major Restorative	Class III	Class III	12 month
Prosthodontics	Class III	Class III	12 month
Misc Rest & Prosth Services	Class III	Class III	12 month
Orthodontics (Adult & Child coverage)	Class IV	Class IV	N/A

- Waived Deductible applies to all Class I services and Class IV Orthodontic services
- Only Basic Restorative Services are covered.
- Prev/Diag services do not count toward annual max.
- Implants are covered at the same percentage as prosthodontics.

Plan Pairings (Groups 10+)

Any one contributory high option can be paired with any one contributory low option.
 Any one voluntary high option can be paired with any one voluntary low option.
 Voluntary plans and contributory plans may not be offered together.
 Exception: DILHM57, DOKHM57 & DNMHM57 can be paired with DILHR33, DOKHR33 and DNMHR33.
 Also: DILHM59, DOKHM59 & DNMHM59 can be paired with DILHR43, DOKHR43 & DNMHR43 respectively
 Also DILHM42, DOKHM42 & DNMHM42 can be paired with any contributory plan.
 And DILHM46, DOKHM46 & DNMHM46 can be paired with any voluntary plan

Participation Requirements for IL

Contributory	Voluntary
>70% participation	>25% participation
>50% employer contribution	<50% employer contribution

Diagnostic & Preventive Services

- Dental exams and cleanings (limited to 2 per plan year)
- Bitewing X-rays (four horizontal images or eight vertical radiographic images once every plan year.)
- Full mouth and panoramic X-rays (limited to 1 every 60 months)
- Fluoride treatment (to age 16, 2 per plan year)

Miscellaneous Services

- Sealants - one per permanent (first and second) molar per lifetime for participants under age 14
- Space maintainers - one appliance per arch per lifetime up to age 14

Restorative Services

- Routine fillings (amalgams and resins) - up to one restorative service per tooth every 12 months
- Pin retention
- Simple extractions

General Services

- Intravenous sedation
- General anesthesia
- Emergency care - treatment for the relief of pain when treatment is not performed in conjunction with a definitive treatment or service

Endodontic Services

- Root canals
- Pulp caps
- Apicoectomy / apexification

Periodontic Services

- Scaling and root planning (limited to once per quadrant every 36 months)
- Gingivectomy / gingivoplasty - Benefit for one surgical periodontal procedure every 36 months.
- Osseous surgery - Benefits are limited to one per quadrant every 36 months.
- Periodontal maintenance – (limited to 2 per plan year combines with prophylaxis)
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis - Benefits are limited to one per lifetime.

Oral Surgery Services

- Surgical extractions
- Alveoloplasty
- Vestibuloplasty

Crowns, Inlays / Onlays Services

- Crowns, Inlays / onlays (limited to one per tooth every 8 years)
- Prefabricated posts and cores
- Repair and recementation of crown, inlays / onlays
- Bridges and dentures (limited to one every 8 years)
- Reline / rebase of dentures (limited to once within first 6 months of initial denture installation and then once every 36 months thereafter)
- Addition of tooth or clasp
- Repair of bridges and dentures

TMJ

Not covered

Orthodontics

Coverage dependent on the dental plan chosen. See your Dental Schedule of Coverage for more information.

- Diagnostic orthodontic records and radiographs - Benefits limited to a lifetime maximum of once per participant.
- Limited, interceptive and comprehensive orthodontic treatment (All accumulate to the participants lifetime max).
- Orthodontic retention- Benefits limited to a lifetime maximum of one appliance per Participant.

Implant Services

- Coverage dependent on the dental plan chosen. See your Dental Schedule of Coverage for more information.

Enhanced Benefits

Participants diagnosed and receiving active medical care for the following medical conditions as determined by the plan, such as – pregnancy, diabetes, and cardiovascular disease – may receive one of the following benefits after standard benefits are completed:

One of the following:

- Cleaning
- Periodontal maintenance
- Periodontal scaling and root planing (up to 2 quadrants)
- Enhanced benefits apply to the annual benefit maximum.

Alternate Benefit Language

- Included

Missing Tooth Exclusion Language

- Missing tooth exclusion applies on all plans. Contributory plans waive continuity of coverage rule of 24 months for initial enrollees but apply on new hires.
- Voluntary plans apply waiting period for all members initial enrollees and new hires unless a certificate of coverage is produced.

Deductible Carryover

- Three month carryover is standard with all plans

Dental dependent age

- Dependent children under age 26

Ortho dependent age

- Dependent children under age 19

Blue Balance Funded--Effective Jan. 1, 2026. Plans are subject to change.

PPO Vision Plans

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Plan 8	Plan 9	Plan 10	Plan 11	Plan 12	Plan 13	Plan 14
In Network Services	12/12/24 \$100	12/12/24 \$130	12/12/24 FF \$130	12/12/24 \$130	12/12/24 \$150	12/12/12 \$150	12/12/12 \$150	12/12/24 \$130	12/12/24 \$150	12/12/12 \$150	12/12/12 \$130	12/12/24 \$200	12/12/12 \$200	12/12/24 \$200

Frequency - once every

Eye Exam	12 Months													
Frame	24 Months	24 Months	24 Months	12 Months	24 Months	12 Months	12 Months	24 Months	24 Months	12 Months	12 Months	24 Months	12 Months	24 Months
Spectacle Lenses or Contact Lenses	12 Months													
Contact Lens Eval/ Fitting	NA	NA	12 Months	NA										

Copayments

Eye Exam	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10
Standard Plastic Spectacle Lenses	\$25	\$10	\$10	\$10	\$10	\$10	\$10	\$25	\$25	\$25	\$25	\$10	\$25	\$25
Contact Lens Fit & Follow-Up	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Standard: \$0 copay, paid in full fit and two follow up visits; Premium: \$0 copay, 10% off retail price, then apply \$40 allowance	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium	Up to \$40 for standard; 10% off retail price for premium

Eyeglass Benefit - Frames

Frame	\$0 copay/\$100 Allowance/20% off balance over \$100	\$0 copay/\$130 Allowance/20% off balance over \$130	\$0 copay/\$130 Allowance/20% off balance over \$130	\$0 copay/\$130 Allowance/20% off balance over \$130	\$0 copay/\$150 Allowance/20% off balance over \$150	\$0 copay/\$150 Allowance/20% off balance over \$150	\$0 copay/\$150 Allowance/20% off balance over \$150	\$0 copay/\$130 Allowance/20% off balance over \$130	\$0 copay/\$150 Allowance/20% off balance over \$150	\$0 copay/\$150 Allowance/20% off balance over \$150	\$0 Copay/\$130 Allowance/20% off balance over \$130	\$0 copay/\$200 Allowance/20% off balance over \$200	\$0 copay/\$200 Allowance/20% off balance over \$200	\$0 copay/\$200 Allowance/20% off balance over \$200
-------	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Blue Balance Funded--Effective Jan. 1, 2026. Plans are subject to change.

PPO Vision Plans

In Network Services	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Plan 8	Plan 9	Plan 10	Plan 11	Plan 12	Plan 13	Plan 14
	12/12/24 \$100	12/12/24 \$130	12/12/24 FF \$130	12/12/24 \$130	12/12/24 \$150	12/12/12 \$150	12/12/12 \$150	12/12/24 \$130	12/12/24 \$150	12/12/12 \$150	12/12/12 \$130	12/12/24 \$200	12/12/12 \$200	12/12/24 \$200

Eyeglass Benefit - Standard Plastic Lenses

Single Vision	\$25 copay	\$10 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$10 copay	\$25 copay	\$25 copay					
Bifocal	\$25 copay	\$10 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$10 copay	\$25 copay	\$25 copay					
Trifocal	\$25 copay	\$10 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$10 copay	\$25 copay	\$25 copay					
Lenticular	\$25 copay	\$10 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$10 copay	\$25 copay	\$25 copay					
Standard Progressive	\$90 copay	\$75 copay	\$10 copay	\$90 copay	\$90 copay	\$90 copay	\$90 copay	\$75 copay	\$90 copay	\$90 copay				
Premium Progressive (Tiers 1-3)	\$110/\$120/\$135	\$95 /\$105/\$120	\$95 /\$105/\$120	\$95 /\$105/\$120	\$95 /\$105/\$120	\$95 /\$105/\$120	\$30 /\$40 / \$55	\$110/\$120/\$135	\$110/\$120/\$135	\$110/\$120/\$135	\$110/\$120/\$135	\$95 /\$105/\$120	\$110/\$120/\$135	\$110/\$120/\$135
Premium Progressive (Tier 4)	\$90 copay, 80% of charge less \$120 Allowance	\$75 copay, 80% of charge less \$120 Allowance	\$75 copay, 80% of charge less \$120 Allowance	\$75 copay, 80% of charge less \$120 Allowance	\$75 copay, 80% of charge less \$120 Allowance	\$75 copay, 80% of charge less \$120 Allowance	\$10 copay, 80% of charge less \$120 Allowance	\$90 copay, 80% of charge less \$120 Allowance	\$90 copay, 80% of charge less \$120 Allowance	\$90 copay, 80% of charge less \$120 Allowance	\$90 copay, 80% of charge less \$120 Allowance	\$75 copay, 80% of charge less \$120 Allowance	\$90 copay, 80% of charge less \$120 Allowance	\$90 copay, 80% of charge less \$120 Allowance
Tint (solid and gradient)	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Scratch Resistant Coating	\$15	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Polycarbonate Lenses	\$40 kids & adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults	\$0 kids & \$40 adults
Ultraviolet Coating	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Anti Reflective Coating	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68	\$45/\$57/\$68
High Index Lenses	20% off retail													
Polarized Lenses	20% off retail													
Photochromatic/ Transitions Plastic	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75

Blue Balance Funded--Effective Jan. 1, 2026. Plans are subject to change.

PPO Vision Plans

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Plan 8	Plan 9	Plan 10	Plan 11	Plan 12	Plan 13	Plan 14
In Network Services	12/12/24 \$100	12/12/24 \$130	12/12/24 FF \$130	12/12/24 \$130	12/12/24 \$150	12/12/12 \$150	12/12/12 \$150	12/12/24 \$130	12/12/24 \$150	12/12/12 \$150	12/12/12 \$130	12/12/24 \$200	12/12/12 \$200	12/12/24 \$200

Contact Lenses (in lieu of spectacle lenses)

Conventional	\$25 copay	\$10 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$10 copay	\$25 copay	\$25 copay					
Disposable	\$25 copay	\$10 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$10 copay	\$25 copay	\$25 copay					
Medically Necessary	\$25 copay	\$10 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$10 copay	\$25 copay	\$25 copay					