PRM Medical Plan Matrix 2025-2026

HSA

Product	BlueOptions (PPO) 03748	BlueCare (HMO) 55	BlueOptions (PPO) 03769	BlueOptions (HSA) 05168/9		BlueOptions (PPO) 03559	BlueOptions (PPO) 05360
Cost Sharing - Member's Responsibility							
Deductible (Per Person / Family Aggregate)	$0 / $0	$0 / $0	$500 / $1,500	$1,650 / NA	$3,300 / $3,300	$750 / $2,250	$1,500 / $4,500
Coinsurance (BCBSF pays / Member pays)	100% / 0%	100% / 0%	80% / 20%	100% / 0%	100% / 0%	80% / 20%	80% / 20%
Out of Pocket Maximum (Per Person/Family Aggregate)	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $4,500	$1,650 / NA	$3,300 / $3,300	$3,000 / $6,000	$3,000 / $6,000
Office Services							
Family Physician / Specialist	$10/$20 Copay	$10/$10 Copay	$15/$15 Copay	DED+0%/DED+0%	DED+0%/DED+0%	$20/$35 Copay	$25 / $75 Copay
Preventive Services							
Office Services (Primary / Specialist)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Medical / Surgical Care at a Facility							
Ambulatory Surgical Center (ASC)	$50 Copay	$100 Copay	DED + 20%	DED + 0%	DED + 0%	$100 Copay	DED + 20%
Inpatient Hospital Facility							
Option 1	$250 Copay	$250 Copay	DED + 20%	DED + 0%	DED + 0%	$750 Copay	DED + 20%
Option 2	$500 Copay	NA	NA			$1,000 Copay	
Outpatient Hospital Facility							
Option 1	$100 Copay	$100 Copay	DED + 20%	DED + 0%	DED + 0%	$150 Copay	DED + 20%
Option 2	$200 Copay	NA	NA			$250 Copay	
Emergency and Urgent Care							
Emergency Room Facility (per visit) (Surgery performed or with admit)	$50 Copay	$50 Copay	DED + 20%	DED + 0%	DED + 0%	$100 Copay	DED + 20%
Urgent Care Centers	$20 Copay	$10 Copay	$15 Copay			$35 Copay	$75 Copay
Diagnostic Testing (e.g., Lab, x-ray)							
Independent Clinical Laboratory	$0 Copay	$0 Copay	20%	DED + 0%	DED + 0%	$0 Copay	$0 Copay
Independent Diagnostic Testing Center	$50 Copay	$0 Copay	$15 Copay			$50 Copay	DED + 20%
Outpatient Hospital Facility							
Option 1	$100 Copay	$100 Copay	DED + 20%	DED + 0%	DED + 0%	$150 Copay	DED + 20%
Option 2	$200 Copay	NA	NA			$250 Copay	
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)							
Independent Diagnostic Testing Center	$50 Copay	$0 Copay	$15 Copay	DED + 0%	DED + 0%	$100 Copay	DED + 20%
Outpatient Hospital Facility							
Option 1	$100 Copay	$100 Copay	DED + 20%	DED + 0%	DED + 0%	$150 Copay	DED + 20%
Option 2	$200 Copay	NA	NA			$250 Copay	
Other Special Services and Locations							
Durable Medical Equipment Skilled Nursing Facility Home Health Care Hospice	DED + 0%	$0 Copay	DED + 20%	DED + 0%	DED + 0%	DED + 20%	DED + 20%
Prescription Drugs (Certain Medications subject to Prior Authorization)							
Retail - Generic/Brand/Non-Preferred/Specialty	$10 / $25 / $60	$5 / $25 / $25	$5 / $35 / $35	100% after INN DED	100% after INN DED	$10 / $25 / $60	$10 / $35 / $70
Mail Order - Generic/Brand/Non-Preferred	$20 / $50 / $120	$10 / $50 / $50	$10 / $70 / $70	100% after INN DED	100% after INN DED	$20 / $50 / $120	$20 / $70 / $140
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / $3,000	30% / $3,000	30% / $3,000	DED / $3,000	DED / $3,000	30% / $3,000	30% / $3,000
Hearing Aid Benefit							
$500 for 1st ear; $300 for 2nd ear. One every 36 months.	Included	Included	Included	Included	Included	Included	Included

PRM Medical Plan Matrix 2025-2026

HSA HSA

Product	BlueOptions HDHP (HSA) 05180/1		BlueOptions (PPO) 05904	BlueOptions (PPO) 05901	BlueOptions (PPO) 05787	BlueOptions HDHP (HSA) 05172/3	
Cost Sharing - Member's Responsibility							
Deductible (Per Person / Family Aggregate)	$2,500	$5,000	$2,500 /$5,000	$2,000 / NA	$7,350 / $14,700	$5,000 / NA	$5,000 / $10,000
Coinsurance (BCBSF pays / Member pays)	100% / 0%	100% / 0%	80% / 20%	50% / 50%	100% / 0%	90% / 10%	90% / 10%
Out of Pocket Maximum (Per Person/Family Aggregate)	$2,500	$5,000	$6,000 / $12,000	$6,350 / $12,800	$7,350 / $14,700	$6,850 / NA	$6,850 / $13,700
Office Services							
Family Physician / Specialist	DED+0% / DED+0%	DED+0%/DED+0%	$35 / $75 Copay	$35 / $75 Copay	$45 / $90 Copay	DED+10%/DED+10%	DED+10% DED+10%
Preventive Services							
Office Services (Primary / Specialist)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Medical / Surgical Care at a Facility							
Ambulatory Surgical Center (ASC)	DED + 0%	DED + 0%	DED + 20%	DED + 50%	DED + 0%	DED + 10%	DED + 10%
Inpatient Hospital Facility							
Option 1	DED + 0%	DED + 0%	DED + 20%	$2,000 Copay	DED + 0%	DED + 10%	DED + 10%
Option 2				$3,000 Copay			
Outpatient Hospital Facility							
Option 1	DED + 0%	DED + 0%	DED + 20%	$300 Copay	DED + 0%	DED + 10%	DED + 10%
Option 2				$400 Copay			
Emergency and Urgent Care							
Emergency Room Facility (per visit) (Surgery performed or with admit)	DED + 0%	DED + 0%	DED + 20%	DED + 50%	DED + 0%	DED + 10%	DED + 10%
Urgent Care Centers			$75 Copay	$75 Copay	$90 Copay		
Diagnostic Testing (e.g., Lab, x-ray)							
Independent Clinical Laboratory	DED + 0%	DED + 0%	$0 Copay	$0 Copay	$0 Copay	DED + 0%	DED + 0%
Independent Diagnostic Testing Center			$50 Copay	$50 Copay	$75 Copay	DED + 10%	DED + 10%
Outpatient Hospital Facility							
Option 1	DED + 0%	DED + 0%	$250 Copay	$300 Copay	DED + 0%	DED + 10%	DED + 10%
Option 2			DED + 20%	$400 Copay			
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)							
Independent Diagnostic Testing Center	DED + 0%	DED + 0%	DED + 20%	$200 Copay	DED + 0%	DED + 10%	DED + 10%
Outpatient Hospital Facility							
Option 1	DED + 0%	DED + 0%	DED + 20%	$300 Copay	DED + 0%	DED + 10%	DED + 10%
Option 2				$400 Copay			
Other Special Services and Locations							
Durable Medical Equipment	DED + 0%	DED + 0%	DED + 20%	DED + 50%	DED + 0%	DED + 10%	DED + 10%
Skilled Nursing Facility							
Home Health Care							
Hospice							
Prescription Drugs (Certain Medications subject to Prior Authorization)							
Retail - Generic/Brand/Non-Preferred/Specialty	100% after INN DED	100% after INN DED	$10 / $50 / $80 / $120	$10 / $60 / $100 / $120	$10 / $60 / $100 /$120	10% after INN DED	10% after INN DED
Mail Order - Generic/Brand/Non-Preferred	100% after INN DED	100% after INN DED	$20 / $100 / $160	$30 / $180 / $300	$30 / $180 / $300	10% after INN DED	10% after INN DED
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	DED / $3,000	DED / $3,000	30% / $3,000	30% / $3,000	30% / $3,000	30% / $3,000	30% / $3,000
Hearing Aid Benefit							
$500 for 1st ear; $300 for 2nd ear. One every 36 months.	Included	Included	Included	Included	Included	Included	Included